Film G137 Item 18-11-2-51 ams

Within corporate limits

DR. HODGES

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09400

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.; LENGTH OF STAY (in this place) 29 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA; COUNTY Hampshire; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROMNEY; STREET ADDRESS (If rural, give location)

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| RAMONA | E. | ALBRIGHT | OCTOBER 16 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | JULY 22 1925 | 26 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | WEST VIRGINIA | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| STINE HOCKMAN | GRACE McGEE |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Generalized Peritonitis. | 3 wks. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Intestinal Obstruction | |
| 191X 55 | (c) (Metastatic Sarcoma) Primary site Scapula. (11-2-51 ams) | ? |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-19-51 | Intestinal Obstruction & Peritonitis | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 9-16, 19 51, to Oct. 16, 19 51, that I last saw the deceased alive on ..., 19..., and that death occurred at ...m., from the causes and on the date stated above.

SIGNATURE: Joyce Hodges (Degree or title) M.D. ADDRESS Cumberland, Md. DATE SIGNED 10/16/51.

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-19-1951 | Ebenezer Cemetery | Romney, W.Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 17, 1951 | Virgil L. Kantz, M.D. | Meyrl Coulb | Romney, W.Va. |

RECEIVED
OCT 24 1951
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09401

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15A

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 6 months; HOSPITAL OR INSTITUTION OR STREET ADDRESS 137 N. Mechanic St. Southern Hotel

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (Number and street or location) 137 N. Mechanic St. Southern Hotel

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|
| | Lowell | E | Alderton | Oct. | 6 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | divorced | May 10-1901 | 50 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bartender | Carolan's Tavern | Green Ridge, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Cecil Alderton | Alberta Troutman |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | 212-12-8830 | Brother) Wm. H. Alderton, Cumberland, Md |

### 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | ? |
| | (c) | |

420.1 94a 322.0

| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |
|---|---|---|
| | Acute Alcoholism | 2 weeks |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H. V. Deming M.D. H. V. Deming M.D. | Cumberland, Md. | Oct. 6-1951 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 9, 1951 | Hillcrest Burial Park | Cumberland, Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 9, 1951 | Winter K. Hartz, M.D. | John J. Hofer, Cumberland, Md | |

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DR. HODGES

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

09402

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ROUTE # 6 POTOMAC PARK
STREET ADDRESS (If rural, give location): Near Cumberland, Rural

3. NAME OF DECEASED (Type or Print): (First) BABY (Middle) GIRL (Last) ALKIRE

4. DATE OF DEATH: (Month) 10 (Day) 9 (Year) 1951

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: 10/5/1951

9. AGE last birthday: ____ yrs. If under 1 year: Months ____ Days 4 — If under 24 hrs.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ____

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): MARYLAND, Cumberland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES A. ALKIRE

14. MOTHER'S MAIDEN NAME: BETTY G. WATSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH: 4 Days

Immediate cause (a) Meningocele

751 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 757.2

(b) Hydrocephalous

(c) Intestinal Hemorrhage

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ____

19b. MAJOR FINDINGS OF OPERATION: ____

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ____

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ____ (CITY OR TOWN) ____ (COUNTY) ____ (STATE) ____

TIME OF INJURY (Month) (Day) (Year) (Hour) ____ m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/5, 1951, to 10/9, 1951, that I last saw the deceased alive on ____, 19____, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. Royce Hodges, M.D. ADDRESS: Cumberland, Md. DATE SIGNED: 10/10/51

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation — DATE THEREOF: Oct. 10, 1951 — NAME OF CEMETERY OR CREMATORY: Memorial Hospital — LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: Oct. 10, 1951 — REGISTRAR'S SIGNATURE: Walter K. Wantz, M.D. — 24. FUNERAL DIRECTOR: Memorial Hospital — ADDRESS: Cumberland, Md.

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BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

9403

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; MARYLAND; LENGTH OF STAY (in this place) 4 mos.; HOSPITAL OR INSTITUTION OR STREET ADDRESS High St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton; STREET ADDRESS Barton (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Lola (Middle) Frances (Last) Andrews

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 19 51

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 16, 1904

9. AGE last birthday: 47 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David W. Mangold

14. MOTHER'S MAIDEN NAME: Lena Maphis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Wheeler Andrews--Barton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Mucous Plugging of Bronchial tubes | |
| 163X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Bronchitis - Lung Abscess | 2 da. |
| 47c | (c) Bronchial Carcinoma | 1 yr. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1951, to Oct 6, 1951, that I last saw the deceased alive on Oct 5, 1951, and that death occurred at 9:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Paul Eugene Drye M.D ADDRESS: Lonaconing Md. DATE SIGNED: 10/7/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: Oct. 8, 1951; NAME OF CEMETERY OR CREMATORY: Laurel Hill Cem.; LOCATION (City, town, or county) (State): Moscow, Maryland

DATE REC'D BY LOCAL REG.: 10-8-51; REGISTRAR'S SIGNATURE: Jeanette M Boal

24. FUNERAL DIRECTOR: Ellsworth S. Boal, Westernport, Md. ADDRESS:

RECEIVED
OCT 15 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09404

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Paw Paw, W.Va. (P.O.) — LENGTH OF STAY (In this place): 2 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Kiefer, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: R.F.D.#1 rural) Paw Paw, W.Va. (P.O.)
STREET ADDRESS (If rural, give location): Kiefer, Md.

3. NAME OF DECEASED (Type or Print): (First) Karen (Middle) (Last) Appold-Turn

4. DATE OF DEATH: (Month) Oct. (Day) 3 (Year) 1951

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Jan. 29-1951

9. AGE last birthday: 0 yrs. — If under 1 year: Months 8 — Days 2 — If under 24 hrs: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Berkley Springs, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Russell W. Appold

14. MOTHER'S MAIDEN NAME: Norma Marie Mueller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: C.C. Nixon, Kiefer, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Suffocation & 3rd & 4th. degree burns of body | about 1/2 hr. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Legs burned, arms burned off. abdomen burned | |
| 916.0 180 | (c) intestines protruding, facial tissue burned | off. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home — (CITY OR TOWN): rural) Kifer — (COUNTY): Allegany — (STATE): Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY: Oct. 3-1951 5:45 P.m. — INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? House caught fire, baby burned to death.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V. Deming M.D. H.V. Deming M.D. | | Cumberland, Md. | Oct. 4-1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 4 1951 | Sulphur Springs Cem | West Kifer, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 5. 1951 | Mrs. Sue C. Sinevan | W.D. Parks, Berkeley Springs, W. Va. | |

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VS. A16A

RECEIVED
OCT 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

C6365

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15A

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 3 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Kiefer
STREET ADDRESS (If rural, give location): (P.O) R.F.D1 Paw Paw, W.Va.

3. NAME OF DECEASED (Type or Print): Sharon (First) (Middle) Appold - Twin (Last)

4. DATE OF DEATH: Oct. 3 (Month) (Day) 1951 (Year)

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH: Jan. 29-1951

9. AGE Last birthday: 0 yrs. If under 1 year: Months 8, Days 4. If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Berkley Springs, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Russell W. Appold

14. MOTHER'S MAIDEN NAME: Norma Marie Mueller

15. WAS DECEASED EVER IN U.S. ARMED FORCE.? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: C.C. Nixon, Kiefer, Md.

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Shock and 3rd. degree burns, legs & part of — Interval Between Onset and Death: 3 1/2 hr

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b): thighs, part of abdomen & chest also face.

916.0
180

(c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY* OR CONTRIBUTING* CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home — (CITY OR TOWN): rural Kiefer Md. — (COUNTY): Allegany — (STATE): Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY: Oct. 3-1951 5.45 p.m.

INJURY OCCURRED While at work ☐ Not while at work ☒*

HOW DID INJURY OCCUR? House caught fire & burned baby.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐*, Inquiry ☐* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐* suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. — ADDRESS: H.V. Deming M.D. Cumberland, Md. — DATE SIGNED: Oct. 4-1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 4, 1951 — NAME OF CEMETERY OR CREMATORY: Sulphur Springs Cem — LOCATION (City, town, or county) (State): Near Kiefer, Maryland

DATE REC'D BY LOCAL REG.: Oct. 4, 1951 — REGISTRAR'S SIGNATURE: Walter R. Dantz, M.D. — 24. FUNERAL DIRECTOR: D.D. Parks, Berkeley Springs — ADDRESS: West Virginia

91

BUREAU U. S.

Within corporate limits

M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place).
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 523 Woodside Ave

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Wilson (Last) Ault

4. DATE OF DEATH: (Month) Oct (Day) 25 (Year) 1951

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug 31 1910

9. AGE last birthday: 41 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Clerical Corp

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob H Ault

14. MOTHER'S MAIDEN NAME: Ardella A Carson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-1633

17. INFORMANT AND ADDRESS: Mrs Charlotte Ault, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Failure

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Coronary Occlusion
(c) Coronary Heart Disease

INTERVAL BETWEEN ONSET AND DEATH: (a) Hours (b) Yrs. (c) Yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1951, to Oct 25 1951, that I last saw the deceased alive on Oct 25, 1951, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edward Hearn MD — 40 Decatur — Oct 25 1951

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial

DATE THEREOF: Oct 27 51

NAME OF CEMETERY OR CREMATORY: Rose Hill Cem

LOCATION (City, town, or county): Cumberland (State): Md.

DATE REC'D BY LOCAL REG. Oct. 27, 1951

REGISTRAR'S SIGNATURE: Walter R. Beard, M.D.

24. FUNERAL DIRECTOR ADDRESS: Louis Stein Inc. Cumberland

DR. GROVE

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05997

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE WEST VIRGINIA — COUNTY MORGAN
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PAW PAW
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) C. (Last) BARKER

4. DATE OF DEATH: (Month) (Day) (Year) 10/5/1951

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 1/2/1884

9. AGE last birthday: 67 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Track Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R.

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES BARKER

14. MOTHER'S MAIDEN NAME: CATHERINE DICKERHOFF

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Generalized Peritonitis — 4 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Perforated marginal ulcer. — 4 days

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 10+ yrs.

19a. DATE OF OPERATION: 10-5-51

19b. MAJOR FINDINGS OF OPERATION: Peritonitis - perforated marginal (Peptic) Ulcer

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 4, 1951, to Oct 5, 1951, that I last saw the deceased alive on Oct 5, 1951, and that death occurred at 9:30 P.M. from the causes and on the date stated above.

SIGNATURE: A.B. Grove (Degree or title) M.D. ADDRESS: Cumberland Md DATE SIGNED: Oct 5, 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 10-8-1951 — NAME OF CEMETERY OR CREMATORY: Camp Hill Cemetery — LOCATION (City, town, or county) (State): Paw Paw W.Va.

DATE REC'D BY LOCAL REG.: Oct. 7, 1951 — REGISTRAR'S SIGNATURE: Walter L. Hartz, M.D.

24. FUNERAL DIRECTOR: W.D. Parks, Berkeley Springs, W.Va. — ADDRESS

within corporate limits.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

69408

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Alleany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Alleany County Infirmery

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Alleany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
STREET ADDRESS (If rural, give location)

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Allen | | Barnard | 10 | 13 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Divorced | 12/24/77 | 73 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retd. Coal Miner | Retd. Coal Mine | Maryland | USA. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Michael Barnard | Mary [illegible] Maryland |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | Reuben Lewis, Eckhart, Md. |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause (a) | Cerebral Vascular Accident | 3 days |
| 321 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83a (b) | General arteriosclerosis | 15 yrs |
| (c) | | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify, that I attended the deceased from Dec., 19 46, to Oct 15, 1951, that I last saw the deceased alive on Oct. 12, 1951, and that death occurred at 9:00 a m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arthur F. Jones | M. D. | 110 S. Centre St. | Oct. 14, 1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 10-15-51 | Eckhart | Eckhart, | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 15, 1951 | Miner L. Lantz, M.D. | Joseph R. Durst | Frostburg, Md. |

RECEIVED
OCT
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Flintstone
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Star Rt., Flintstone, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Flintstone
STREET ADDRESS (If rural, give location) Star Rt., Flintstone, Md.

3. NAME OF DECEASED (Type or Print): (First) Frederick (Middle) Madison (Last) Bible

4. DATE OF DEATH (Month) Oct (Day) 17 (Year) 1951

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH May 23, 1897

9. AGE Last birthday 54 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire builder

10b. KIND OF BUSINESS OR INDUSTRY K-S Tire Co.

11. BIRTHPLACE (State or foreign country) Pendleton Co., W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James W. Bible

14. MOTHER'S MAIDEN NAME Ida Morrall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-07-1353

17. INFORMANT AND ADDRESS Mrs. Mabel Bible, Star Rt., Flintstone, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Chronic myocarditis | 2 yrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary thrombosis | 1 yr. ago |
| | (c) Malnutrition, Secondary anemia | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 51, to Oct 17, 19 51, that I last saw the deceased alive on Oct 17, 19 51, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Emile R. Everhart M.D. ADDRESS 36 Greene St City DATE SIGNED 11/19/51

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial

DATE THEREOF Oct 20, 1951

NAME OF CEMETERY OR CREMATORY Glendale Brethren Cemetery

LOCATION (City, town, or county) Flintstone (State) Md.

DATE REC'D BY LOCAL REG. Oct 20, 1951

REGISTRAR'S SIGNATURE Nina L. Bender

24. FUNERAL DIRECTOR John F. Hafer, Cumberland, Md. ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

09410

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany | MARYLAND | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (In this place) | HOSPITAL OR INSTITUTION OR STREET ADDRESS: dead on arrival at the Memorial Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pa. COUNTY: Allegheny | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pittsburg (Stationed at Norfolk Navy Base) | STREET ADDRESS (If rural, give location): 938 Kirkbridge St.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) A. (Last) Bischoff

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1951

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Dec. 6-1929

9. AGE last birthday: 21 yrs. | If under 1 year: Months / Days. | If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Naval Air Station, Norfolk, Va.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pittsburgh, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Bischoff

14. MOTHER'S MAIDEN NAME: Mary Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): yes in the Navy.

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Cards in pocket book.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Hemorrhage due to basal fracture | about 2 |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) of the skull, also had fracture of both malar, nasal & superior Maxillary bone. | hours. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY (*) OR CONTRIBUTING (*) CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway Route 50 near (CITY OR TOWN) Augusta (COUNTY) Hampshire Mineral (STATE) W.Va.

TIME OF INJURY (Month) Oct. (Day) 6/51 (Hour) 8:30 A. m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Head on collision auto. with coal truck, then over bank.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒; thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V. Deming M.D. | H. V. Deming M.D. | Cumberland, Md. | Oct. 6-1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10- 10-1951 | North Side Cath. Cem. | West View, Pa. |

| DATE RECD BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 8, 1951 | Walter L. Wantz, M.D. | Charles L. George | Cumberland, Md. |

VS. A16A

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

09411

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

VS. A15A

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: New York — COUNTY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ticonderoga |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Dead on arrival at the Memorial Hospital. | STREET ADDRESS (If rural, give location): Base-V.P. (?) (Norfolk, Va, [illegible]) |

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|
| | Millard | F. [illegible] | Blood | Oct. | 6. | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months | Days | If under 24 hrs: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | Single | Nov. 10-1933 | 17 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Naval Base (U.S.) Norfolk, Va. | | Ticonderoga New York | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Millard B. Blood | Florence. ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| Yes 1951 | | Records from cards in cloths. |

### 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| Immediate cause (a) Cerebral hemorrhage due to a basal fracture | of the |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) skull, also had fracture both maxillary, nasal & left femur, Laceration of left forearm, | about 2 hrs. |
| (c) contusions of body. | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. EXTERNAL CAUSE WAS PRIMARY * OR CONTRIBUTING * CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: highway | near (CITY OR TOWN) Augusta | COUNTY Mineral | (STATE) W.Va. |
|---|---|---|---|---|
| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? | | |
| Oct. 6/51 1.30 A. m. | | Head on collision auto with coal truck. then over bank. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H.V. Deming M.D. H.V. Deming M.D. | Cumberland, Md. | Oct. 6-1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-10-1951 | Valley View Cem. | Ticonderoga, N.Y. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 8, 1951 | Charles L. George M.D. | Charles L. George | Cumberland, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09412

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 323 Avirett Ave.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 323 Avirett Ave.,

3. NAME OF DECEASED (Type or Print): (First) ZADIE (Middle) MAE (Last) BODEN
4. DATE OF DEATH: (Month) Oct. (Day) 13, (Year) 19 51

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Dec. 25, 1895
9. AGE last birthday: 55 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Stay at Home
11. BIRTHPLACE (State or foreign country): Betterton, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Benjamin Nicholson
14. MOTHER'S MAIDEN NAME: Susan Gardener

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. "INFORMANT" AND ADDRESS: Robert F. Boden 323 Avirett Ave.,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma Uterus 2

1714 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) melanosis — 6 mos.

1815 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1957, to 10/13, 1951, that I last saw the deceased alive on 10/12, 1951, and that death occurred at 9:25P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Dewey M Bowman MD Cumberland Md 10/16/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10/16/51
NAME OF CEMETERY OR CREMATORY: Hillcrest Br'l Park
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 16, 1951
REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: Cumberland, Md.

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 60 Years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 1012 Rolling Mill Alley

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 1012 Rolling Mill Alley

3. NAME OF DECEASED (Type or Print): (First) Albert; (Middle) John; (Last) Brown

4. DATE OF DEATH: (Month) Oct; (Day) 29; (Year) 19 51

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb 17 1879

9. AGE Last birthday: 72 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Labor

10b. KIND OF BUSINESS OR INDUSTRY: B & O RR.

11. BIRTHPLACE (State or foreign country): Rawlings, Laryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Albert Brown

14. MOTHER'S MAIDEN NAME: Agnes Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No; (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs. Bessie Brown, Cumberland, Maryland 1012 Rolling Mill Alley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypertension Heart disease — Interval Between Onset and Death: and years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) Chr. Nephritis — 10 month

4438 / 1315

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Debility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1951, to Oct 30, 1951, that I last saw the deceased alive on Oct 8, 1951, and that death occurred at 4:20 P.m., from the causes and on the date stated above.

SIGNATURE: Alan F. Hemmy M.D. (Degree or title) ADDRESS: Cumberland DATE SIGNED: Oct

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: Oct31 1951; NAME OF CEMETERY OR CREMATORY: Sumner Cemetery; LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG. Oct 30, 1951; REGISTRAR'S SIGNATURE: Minnie L. Lantz M.D.

24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md. ADDRESS

DR. R. WILLIAMS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. | LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE PENNA. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEDFORD
STREET ADDRESS (If rural, give location) RT. #3

3. NAME OF DECEASED (Type or Print) (First) BERTHA (Middle) Viola (Last) BRUNER
4. DATE OF DEATH (Month) OCT. (Day) 20 (Year) 1951
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH JAN. 17 1898
9. AGE Last birthday 53 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) PENNA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MORGAN OLIVER
14. MOTHER'S MAIDEN NAME Jane Gillum
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-30-9924
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Acute Myocardium | about |
| 14.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Pneumonia | Hours |
| Mar | (c) | |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-16, 1951, to 10-20, 1951, that I last saw the deceased alive on 10-21, 1951, and that death occurred at 3:15 P m., from the causes and on the date stated above.

SIGNATURE W. R. Williams (Degree or title) MD ADDRESS Cumberland DATE SIGNED 10-20-51

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 10/22/51 | Bethel Methodist | Bedford Co. | Pa. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 22, 1951 | Winter K. Hartz, M.D. | John L. Hoffer | Cumberland, Md. |

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. W.F.WMS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
LENGTH OF STAY (in this place): 42 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: FROSTBURG Rural
STREET ADDRESS (If rural, give location): R.F.D. #1, Woodland

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) H. (Last) BUSKIRK

4. DATE OF DEATH: (Month) OCT. (Day) 29 (Year) 1951

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: DEC. 17 1901

9. AGE last birthday: 49 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe-fitter

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: USA.

13. FATHER'S NAME: JOHN BUSKIRK

14. MOTHER'S MAIDEN NAME: JENNIE DUNN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-09-7342

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinomatosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Primary Focus undetermined

(c)

Interval between onset and death: (a) about 2 mos

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 3, 1951, to Oct 29 1951, that I last saw the deceased alive on Oct 29, 1951, and that death occurred at 11:15A m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) MD ADDRESS: Frostburg DATE SIGNED: 10-29-51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Nov 1 1951

NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

LOCATION (City, town, or county) (State): Frostburg, Maryland

DATE REC'D BY LOCAL REG.: Oct. 30, 1951

REGISTRAR'S SIGNATURE: Winter K. Lantz, MD

24. FUNERAL DIRECTOR: Lafferl Funeral Home

ADDRESS: Frostburg, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 20 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 208 Tamarack Place

3. NAME OF DECEASED (Type or Print): (First) NEHEMIAH (Middle) (Last) CARTER

4. DATE OF DEATH: (Month) Oct. (Day) 19 (Year) 1951

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 1, 1899

9. AGE last birthday: 52 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engine watcher

10b. KIND OF BUSINESS OR INDUSTRY: R.R. Railroad

11. BIRTHPLACE (State or foreign country): Littleton, North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Carter

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-10-4956

17. INFORMANT AND ADDRESS: Elizabeth Carter, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Uremia | 4 wks. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Malignant Hypertension | unknown |
| | (c) | |

445X
102

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 22, 1951, to Oct 19, 1951, that I last saw the deceased alive on Oct 15, 1951, and that death occurred at 2 30/A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Olive Ratliff Rock, M.D. 202 Virginia Ave. Cumberland Md.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF 10/22/1951; NAME OF CEMETERY OR CREMATORY Mount Olive Cemetery; LOCATION (City, town, or county) (State) Littleton, North Carolina

DATE REC'D BY LOCAL REG. Oct. 20, 1951; REGISTRAR'S SIGNATURE Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Wm. H. Kight Cumberland, Md.

VS. A15

DR. SCHINDLER
2:30

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09417

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 6 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 16 NORTH LEE STREET

3. NAME OF DECEASED (Type or Print): (First) BABY GIRL (Middle) (Last) CLAIR

4. DATE OF DEATH: (Month) 10 (Day) 21 (Year) 1951

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: 10/21/1951

9. AGE last birthday: yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours 5 — Min. 17

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY? Usa.

13. FATHER'S NAME: JOHN A. CLAIR

14. MOTHER'S MAIDEN NAME: JOANNE MC GANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Atelectasis & Hypotonegaly — Interval Between Onset and Death: 6 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) Unborn — 756.2

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/21, 1951, to 10/21, 1951, that I last saw the deceased alive on 10/21, 1951, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE: B. M. Schindler (Degree or title) M.D. ADDRESS 41 Greenway Cumberland Md DATE SIGNED 10/24/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 23, 1951 — NAME OF CEMETERY OR CREMATORY: St. Mary's Cem. — LOCATION (City, town, or county) (State): Lonaconing Md.

DATE REC'D BY LOCAL REG.: Oct. 23, 1951 — REGISTRAR'S SIGNATURE: Wintey K. Hoover, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Louis Stein Inc. Cumb. Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct a... is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

09418

Reg. Dist. No. 8

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place) 80yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Church Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Church Street

3. NAME OF DECEASED (Type or Print) (First) Elizabeth (Middle) (Last) Cosgrove

4. DATE OF DEATH (Month) (Day) (Year) Oct, 9. 1951 19

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH Oct, 9, 1865

9. AGE last birthday 86 yrs.

If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Shaft, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Peter Wagner

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. None

17. INFORMANT Christina Gillis (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Pulmonary Hemorrhage | 1 day |
| 422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Bronchiectasis | 2 yrs. |
| 93d | (c) Chronic Myocarditis | 2 yrs. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1 ..., 1951, to Oct 9 ..., 1951, that I last saw the deceased alive on Oct 9 ..., 1951, and that death occurred at ?.....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Thomas Reece M.D. Westernport Md 10/10/51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Oct. 12 1951

NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park

LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REG. 10-11-51

REGISTRAR'S SIGNATURE Jeannette M Pool

24. FUNERAL DIRECTOR M. Eichhorn

ADDRESS Lonaconing, Md.

DR. SCHINDLER

Within corporate limits

12:30
11:30

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

U5419

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 22 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL
MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 122 UTAH AVENUE

3. NAME OF DECEASED (Type or Print): (First) BABY (Middle) GIRL (Last) DAVIS

4. DATE OF DEATH: (Month) 10 (Day) 21 (Year) 1951

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: 10/20/1951

9. AGE last birthday: yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours 21 Min. 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: ROY FRANKLIN DAVIS

14. MOTHER'S MAIDEN NAME: ELIZABETH V. JACK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Prematurity — Interval between onset and death: 1 day

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b):
(c):

776 X
159

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/20/51, 19..., to 10/21/51, 19..., that I last saw the deceased alive on 10/21/51, 19..., and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H M Schindler M.D. ADDRESS: 71 Emmett Cumberland Md. DATE SIGNED: 10/24/51

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation
DATE THEREOF: Oct. 22, 1951
NAME OF CEMETERY OR CREMATORY: Memorial Hospital
LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: Oct. 22, 1951
REGISTRAR'S SIGNATURE: Wilbur R. Wantz, M.D.
24. FUNERAL DIRECTOR: Memorial Hospital ADDRESS: Cumberland, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany | MARYLAND | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg | LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa. COUNTY Somerset. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wellersburg STREET ADDRESS (If rural, give location) P.O. Box 5.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Baby | Girl | Dom | 10 | 14 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | W | [illegible] | 10-18-51 | 0 yrs. | | | 5 | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| [illegible] | | Frostburg, Md | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wilbert H. Dom | Madelind M. Kennel |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| | | — | Mother. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Anencephalus Child

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 757X 157C

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | — | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| — | | — | — | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | — |

22. I hereby certify that I attended the deceased from 10-18, 1951, to 10-18, 1951, that I last saw the deceased alive on 10-18, 1951, and that death occurred at 11:22 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. C. Diehl, M.D. Frostburg, Md. 10/18/51

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-18-51 | Zion Reformed Cem | Wellersburg, Pa. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-18-51 | Mrs Nancy N. Poe | Wilbert H. Dom | Wellersburg Pa. |

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

0[illegible]21

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Alleany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Alle_any County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Alle any
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke, Md.
STREET ADDRESS (If rural, give location) Cromwell Street

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| John | William | Dunn | 10 | 31 | 19 51 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Oct 7 1867 | 84 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Paperfitter | Luke Paper Mill | W. Va., Mineral County | U.S.A. |

13. FATHER'S NAME: Isaac Dunn
14. MOTHER'S MAIDEN NAME: Amanda Swindler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Bruce Dunn, Son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocardial Failure | 6 wks |
| 420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a | (b) Coronary Sclerosis | 5 yrs |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Sept. 15, 1949, to Oct. 31, 1951, that I last saw the deceased alive on Oct. 29, 1951, and that death occurred at 5:55 a m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arthur F. Jones | M.D. | 110 S. Centre St. | |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 2 1951 | Ft Ashby Cemetery | Ft. Ashby, West Virginia |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 31, 1951 | Virgil L. Hanby M.D. | E. S. Boal | Westernport Maryland |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 7

Within Corporate Limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09422

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 53 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1105 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1105 Bedford St

3. NAME OF DECEASED (Type or Print) (First) SARAH (Middle) E. (Last) EICHNER

4. DATE OF DEATH (Month) Oct. (Day) 6, (Year) 1951

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH July 20, 1874

9. AGE Last birthday 77 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wm. C. BRAY

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT AND ADDRESS W.E. Eichner, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Broncho Pneumonia — 10 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis — 450.0 / 107

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8:21, 1949, to 10:6:, 1951, that I last saw the deceased alive on 10:6:, 1951, and that death occurred at 6:20 P.m., from the causes and on the date stated above.

SIGNATURE Wm. F. Williams — (Degree or title) MD — ADDRESS Cumberland — DATE SIGNED 10-8-51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10-9-1951 — NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery — LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REG. Oct. 9, 1951 — REGISTRAR'S SIGNATURE Walter R. Mantz, M.D. — 24. FUNERAL DIRECTOR Wm H. Right — ADDRESS Cumberland, Md.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH**
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 2 yrs. 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 509 Schriver Ave

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 509 Schriver Ave.

**3. NAME OF DECEASED** (Type or Print): (First) Clarence (Middle) L. (Last) Fisher

**4. DATE OF DEATH**: (Month) Oct. (Day) 1, (Year) 1957.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | Aug. 10, 1872 | 79 yrs. | | |

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired Grocer
**10b. KIND OF BUSINESS OR INDUSTRY**: Gen. Store
**11. BIRTHPLACE** (State or foreign country): Berlin, Pa.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Daniel Fisher
**14. MOTHER'S MAIDEN NAME**: Catherine Wolfley

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service): no
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT AND ADDRESS**: Mrs. Robert K. Garner, 506 Shriver Ave. Cumberland Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**Immediate cause** (a) Generalized Arteriosclerosis — Interval Between Onset and Death: Several years.

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 450.0 97
(b) General Debility
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION** | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-24, 1949, to 10-1-, 1957., that I last saw the deceased alive on 9-25, 1957, and that death occurred at 8:25 P. m., from the causes and on the date stated above.

SIGNATURE: Wm. F. Wilkins — (Degree or title) M.D. — ADDRESS: Cumberland — DATE SIGNED: 10-1-57

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 4 1957 | I.O.O.F Cemetery | Berlin, Pa. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 1, 1957 | Winter K. Frantz, M.D. | H.G. Johnson | Berlin, Pa. |

VS. A15

RE
OCT 8
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rawlings; STREET ADDRESS (If rural give location)

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Rebecca | L. | Flanagan | October | 29 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | unknown | 75 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | At Home | West Virginia | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | none | Alice Flanagan, Rawlings, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pneumonia, bronchial

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocardial degeneration

(c) Cardiac decompensation

4/22.2 93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 10/22, 1951, to 10/29, 1951, that I last saw the deceased alive on 10/26, 1951, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| George M Jepson | M.D. | Cumberland, Md. | 10/29/51 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/51 | Bintown Cemetery | Near Rawlings, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 31, 1951 | Walter K. Hartz, M.D. | Louis Stein, Inc. | Cumberland, Md. |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Reeves

# CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (in this place) 28 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 246 Main St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) 246 Main St.

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) ELLIS (Last) FRANKS

4. DATE OF DEATH: (Month) October (Day) 29 (Year) 1951

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 11 April 1873

9. AGE last birthday: 78 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. R. E. Franks

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Bronchopneumonia (Terminal) | 1 yr |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic Myocarditis | 14 yrs |
| | (c) Chronic Nephritis | 6 mos. |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anasarca — 2 wks.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1951, to Oct 24, 1951, that I last saw the deceased alive on 10/29, 1951, and that death occurred at A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Norman Reeves M.D ADDRESS Westernport Md DATE SIGNED 10/31/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 31 Oct 51

NAME OF CEMETERY OR CREMATORY: Bloomington Cemetery

LOCATION (City, town, or county) (State): Bloomington, Maryland

DATE REC'D BY LOCAL REG.: Oct 31, 1951

REGISTRAR'S SIGNATURE: Mrs Jane C Kelly

24. FUNERAL DIRECTOR: E. S. Boal ADDRESS: Westernport, Md.

VS/A15

RECEIVED
NOV 1 1951
BUREAU M. S.

DR. WHITWORTH

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 513 VIRGINIA AVENUE

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) A. (Last) FULTON

4. DATE OF DEATH: (Month) OCT. (Day) 7, (Year) 19 51

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: APRIL 4, 1892

9. AGE last birthday: 59 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK O'BAKER

14. MOTHER'S MAIDEN NAME: NELLIE MARTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-14-4397

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) II Diabetes (Severe)
(c) Anuria Complete

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Oct, 19 51, to 7 Oct, 19 51 that I last saw the deceased alive on 1 Oct, 19 51 and that death occurred at 6:20 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Miller B. Whitworth M.D. | ADDRESS Cumberland Md | DATE SIGNED 7 Oct 51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 10-10-1951 | NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem. | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Oct. 9, 1951 | REGISTRAR'S SIGNATURE Winter R. Mantz, M.D. | 24. FUNERAL DIRECTOR Charles L. George | ADDRESS Cumberland, Md.

11-2-51 ams

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS: A15

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

09127

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1014 Virginia Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 1014 Virginia Ave.

3. NAME OF DECEASED (Type or Print): (First) Walter (Middle) Earl (Last) Furr

4. DATE OF DEATH: (Month) Oct (Day) 22 (Year) 1951

5. SEX: mal■

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 12-1885

9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinest, backshop at

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry.

11. BIRTHPLACE (State or foreign country): Spring Hollow, Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Stewart Furr

14. MOTHER'S MAIDEN NAME: Savilla --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: 705-05-5326

17. INFORMANT AND ADDRESS: Chas. A. Stinebaugh, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary occlusion due to | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis also had | ? |
| | (c) chronic myocarditis | ? |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or Title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland, Md. Oct. 23-1951

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Oct 25 1951 — NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 24, 1951 — REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

09426

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ALICE (Middle) CAREY (Last) GALVIN

4. DATE OF DEATH: (Month) Oct. (Day) 26, (Year) 1951

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: June 12-1869

9. AGE last birthday: 82 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Galvin

14. MOTHER'S MAIDEN NAME: Rose Ann Carey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Loretta McDermitt, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Mitral Stenosis — Interval Between Onset and Death: Several Years

421.4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Varicose Hypertension — Several Years

421.1 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1, 1951, to 10-26, 1951, that I last saw the deceased alive on 10-26, 1951, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): William E. Mosley — ADDRESS: Mt Savage, Md. — DATE SIGNED: 10-29-1951

23. BURIAL, CREMATION or REMOVAL (Specify): Burial — DATE THEREOF: Oct. 29 '51 — NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery — LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG. 10-29-1951 — REGISTRAR'S SIGNATURE: Veronica McDermitt

24. FUNERAL DIRECTOR ADDRESS: J. R. Durst, Frostburg, Md.

Permit issued at 8 — Funeral at 9:30

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

09125

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 1 day; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland; STREET ADDRESS (If rural, give location) Rt. 2, Williams Road

3. NAME OF DECEASED (Type or Print): (First) Lucius (Middle) Summerfield (Last) Garland

4. DATE OF DEATH: (Month) Oct. (Day) 11 (Year) 1951

5. SEX: M

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug. 13, 1882

9. AGE last birthday: 69 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Springfield, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oliver Garland

14. MOTHER'S MAIDEN NAME: Amanda Chaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Mrs. Helen Garland, Rt. 2, Cumberland, Md.

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Embolus | Instantly |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Myocardial Infarction | 3 days |
| | (c) Coronary artery insufficiency | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Spring, 1951, to Oct. 11, 1951, that I last saw the deceased alive on Oct 11, 1951, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Samuel G. Wiseman MD 59 Greene St Cumberland Oct 12, 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct. 14, 1951 | NAME OF CEMETERY OR CREMATORY: Mt. Tabor Methodist Cemetery | LOCATION (City, town, or county) (State): Spring Gap, Md.

DATE REC'D BY LOCAL REG.: Oct. 12, 1951 | REGISTRAR'S SIGNATURE: Walter K. Mantz, M.D. | 24. FUNERAL DIRECTOR: John J. Hoffman | ADDRESS: Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

19134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; MARYLAND LENGTH OF STAY (in this place): 58 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 243 N.Center St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural, give location): 243 N.Center St.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Henry (Last) Glick

4. DATE OF DEATH: (Month) Oct. (Day) 22 (Year) 1951

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH: Sept.1-1893

9. AGE last birthday: 58 yrs. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired clerk for the Draft Board.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland,Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Glick

14. MOTHER'S MAIDEN NAME: Margaret Gramlich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: 214-05-5456.

17. INFORMANT AND ADDRESS: sister) Marie Glick,Cumberland,Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Coronary occlusion — about 10 min.

420.1 94 a

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland,Md. Oct.22-1951

23. BURIAL, CREMATION REMOVAL (Specify): Burial. DATE THEREOF: Oct. 25/51 NAME OF CEMETERY OR CREMATORY: SS. Peter + Paul's Cem. LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: Oct. 24, 1951 REGISTRAR'S SIGNATURE: Victor K. Frantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc. ADDRESS: Cumberland Md.

Within Corporate Limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

1103

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 216 Central Ave.; LENGTH OF STAY (in this place) 11 Years; MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 216 Central Ave.

3. NAME OF DECEASED (Type or Print): (First) Rose (Middle) A. (Last) Grabenstein

4. DATE OF DEATH: (Month) Oct. (Day) 1 (Year) 19[illegible]1

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: July 24, 1883

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Carlisle, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Simon Smith

14. MOTHER'S MAIDEN NAME: Stella Theresa Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Eugene Howell-123 Pa. Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Embolism — Interval Between Onset and Death: 7 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Nephritis and Myocarditis.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Arthritis.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1947, to Sept. 30, 1951, that I last saw the deceased alive on Sept. 30, 1951, and that death occurred at 4:30 A. m., from the causes and on the date stated above.

SIGNATURE: J. N. Cowherd M. D. (Degree or title) ADDRESS: 41 Green Street, Cumberland, Md. DATE SIGNED: 10/2/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Oct. 2, 1951

NAME OF CEMETERY OR CREMATORY: Sts. Peter & Paul

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 2, 1951

REGISTRAR'S SIGNATURE: Wortes K. Hartz, M.D.

24. FUNERAL DIRECTOR: James F. Cornell-Cumberland ADDRESS: Md.

OCT
U. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 0943 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg | LENGTH OF STAY (in this place) 5 ds
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 5 Mi W. Barton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) William Ellsworth (Middle) Franklin (Last) Green
4. DATE OF DEATH: (Month) Oct. (Day) 14 (Year) 51
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 25 Aug. 1872
9. AGE last birthday: 79 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: George Green
14. MOTHER'S MAIDEN NAME: Annie Winnebrenner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Jesse Green-R.F.D. Barton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Uremia | 8 days |
| 442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a | (b) Hypertensive Cardio Vascular Renal disease | years. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED White at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 7, 1951, to October 14, 1951, that I last saw the deceased alive on 14 October, 1951, and that death occurred at 6:30 A.m., from the causes and on the date stated above.

SIGNATURE: John B. Davis, (Degree or title) M.D. ADDRESS: Frostburg, Maryland DATE SIGNED: 10/15/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 10/16/51 | NAME OF CEMETERY OR CREMATORY: Laurel Hill | LOCATION (City, town, or county) (State): Moscow, Md.

DATE REC'D BY LOCAL REG.: Oct 17, 1951 | REGISTRAR'S SIGNATURE: Mrs Harvey A. Poe | 24. FUNERAL DIRECTOR: Ellsworth S. Boal. ADDRESS: Westernport, Md.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09131

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 27 Weber St.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Mary | Margaret | Cross | 10 | 10 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Oct. 2, 1873 | 78 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own home | Maryland | U.S.A. |

13. FATHER'S NAME: John J. Jenkins

14. MOTHER'S MAIDEN NAME: Margaret Jenkins Stickley

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | Perry B. Gross, 27 Weber St. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Vascular Accident | 45 Min. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) General Arteriosclerosis | 5 yrs. |
| 83a | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While at Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from June 14, 1949, to Oct. 10, 1951, that I last saw the deceased alive on Oct. 10, 1951, and that death occurred at 2:50 p.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arthur F. Jones | M.D. | 110 S. Centre St. | Oct. 11, 1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 13, 1951 | Mt. Pleasant Methodist Cemetery | ~~Spring~~ Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 13, 1951 | Walter R. Frantz, M.D. | John J. Hafer, Cumberland, Md. | |

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

09130

Reg. Dist. No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct... is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D #2 Williams Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural) Cumberland
STREET ADDRESS (If rural, give location): R.F.D.#2 Williams Rd.

3. NAME OF DECEASED (Type or Print): (First) Benjamin (Middle) Franklin (Last) Hall

4. DATE OF DEATH: (Month) Oct. (Day) 31 (Year) 1951

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Oct- ? 1883

9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Hostler for B&O.R.Ry

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: 705-09-9934

17. INFORMANT AND ADDRESS: wife) Flora Anna Hast Hall

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Coronary occlusion due to — at once

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — ?

421.1 94a

(c) Alcoholism

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland, Md. Nov. 1-1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Nov.2, 1951
NAME OF CEMETERY OR CREMATORY: Zion Memorial ark
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Nov. 1, 1951
REGISTRAR'S SIGNATURE: Minnie K. Hantz, M.D.
24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Md. ADDRESS

VS. A15A

C9439

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 1 mile so.of Westernport | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 mi. so. of Westernport

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 1 mile so. of Westernport
STREET ADDRESS (If rural, give location) 1mi. so. of Westernport

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Elizabeth (Last) Halterman

4. DATE OF DEATH: (Month) Oct. (Day) 23 (Year) 19 5

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 12, 1870

9. AGE last birthday: 81 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Jacob R. Mathias

14. MOTHER'S MAIDEN NAME: Lena See

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: L.P. Halterman--Augusta, W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial degeneration — Interval Between Onset and Death: 9 mo

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — 3 mo

131a (c) Cystitis — 3 yr

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 17, 19..., to Oct 23, 19..., that I last saw the deceased alive on Oct 23, 19..., and that death occurred at 6 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Geo. H. Smith M.D. ADDRESS Piedmont DATE SIGNED Oct 24 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct. 25, 1951 | NAME OF CEMETERY OR CREMATORY: Augusta Cemetery | LOCATION (City, town, or county): Augusta, Hampshire Co. (State): W. Va.

DATE REC'D BY LOCAL REG.: Oct 25, 1951 | REGISTRAR'S SIGNATURE: Mrs Jean C. Kelly | FUNERAL DIRECTOR: E.S. Coal | ADDRESS: Westernport, Maryland

VS. A15

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 114 Decatur St.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Riley (Last) Hamilton

4. DATE OF DEATH: (Month) Oct. (Day) 23 (Year) 1951

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: May 23, 1896

9. AGE last birthday: 55 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car inspector

10b. KIND OF BUSINESS OR INDUSTRY: B & O R. R.

11. BIRTHPLACE (State or foreign country): Oldtown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Hanson Hamilton

14. MOTHER'S MAIDEN NAME: Louise Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Andrew Santore, 114 Decatur St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hodgkin's Sarcoma — Interval Between Onset and Death: 2 mo.

201 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

44 X (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-12-51

19b. MAJOR FINDINGS OF OPERATION: Biopsy showed Hodgkin's Sarcoma

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 28, 1951, to Oct. 23, 1951, that I last saw the deceased alive on Oct. 22, 1951, and that death occurred at 7:30 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Reed M. D. 110 S. Centre St. Oct. 24, 1951

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Oct. 25, 1951 — NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 24, 1951 — REGISTRAR'S SIGNATURE: Walter L. Wantz, M.D. — 24. FUNERAL DIRECTOR, ADDRESS: John J. Hoffer, Cumberland, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 140 Green Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 140 Green Street

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) (Last) HARRIS
4. DATE OF DEATH: (Month) Oct. (Day) 29, (Year) 1951

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 2-20-1871
9. AGE last birthday: 80 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Wales
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Jones
14. MOTHER'S MAIDEN NAME: Gwendolyn Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT AND ADDRESS: Tydvil Harris, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Cardiac Dilatation — sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr Myocarditis — 2 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, 19..., to Oct 29, 1951, that I last saw the deceased alive on Sept 4, 1951, and that death occurred at 9004 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
W W McLane MD — Frostburg Md — Oct 30 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 11-1-51 — NAME OF CEMETERY OR CREMATORY: Frostburg Mem'l Park — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 11-1-51 — REGISTRAR'S SIGNATURE: Mrs Nancy N Pre

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 8yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland Rural; STREET ADDRESS (If rural, give location) RD# 3 Bowmans Additions

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| Lydia | Rebecca | Hershiser | Oct. 25, 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year Months | Days | If under 24 hrs. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Aug. 7, 1898 | 53 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | House wife None | New Buena Vista Pa. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Ellsworth Mc. Vicker | Mary Hillegass |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | no | William E. Hershiser, Cumberland Md. RD # 3. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Uremia - | |
| 421.4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Mitral Stenosis-Arteriosclerosis | |
| 420 | (c) & Hypertension | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Oct 11, 1951, to Oct 25 1951, that I last saw the deceased alive on Oct 25, 1951, and that death occurred at 11 A m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| R. B. Mathews M.D. | 49 Greene St Cumberland, Md. | |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/28/1951 | Dry Ridge Cemetery | Manns Choice Pa. RD#1 |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 26, 1951 | Wesley L. Lantz M.D. | Harvey H. Sigler | Hyndman, Pa. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

[9425

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone | LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone
STREET ADDRESS (If rural, give location) R-Route

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Jane (Last) House
4. DATE OF DEATH: (Month) Oct. (Day) 11 (Year) 1951

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed | 8. DATE OF BIRTH: March 28, 1877 | 9. AGE last birthday: 74 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10b. KIND OF BUSINESS OR INDUSTRY: Own home | 11. BIRTHPLACE (State or foreign country): Flintstone, Md. | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Matthew Buley | 14. MOTHER'S MAIDEN NAME: Julia Diehl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT AND ADDRESS: Mrs. Dorothy Smith, Flintstone, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Congestion

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Occlusion

(c) Arteriosclerosis

420.1

INTERVAL BETWEEN ONSET AND DEATH: (a) Few Hours (b) 1 day (c) Many yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

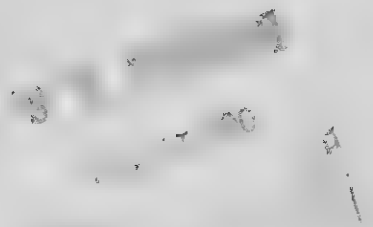
22. I hereby certify that I attended the deceased from Sept. 6, 1951, to Oct. 11, 1951, that I last saw the deceased alive on Oct. 11, 1951, and that death occurred at 6:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Dowell Rice MD 40 Allegany St Oct 13 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct. 13, 1951 | NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 13, 1951 | REGISTRAR'S SIGNATURE: Nina L. Bender. | 24. FUNERAL DIRECTOR ADDRESS: John A. Hafer, Cumberland, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Moscow; LENGTH OF STAY (in this place) 83yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Moscow

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Moscow; STREET ADDRESS (If rural, give location) Moscow

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) Isabell (Last) Hyde

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1951

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 22, 1867

9. AGE last birthday 83 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Mowbray

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS Jennie Hyde --Moscow, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Thrombosis — Interval Between Onset and Death: 3 days

4 + X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

12 1a (b) Chronic Cardiovascular

(c) disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/ , 1951, to 10/6, 1951, that I last saw the deceased alive on Oct 6, 1951, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Raymond A. Frank M.D. Cumberland, Md. 10/8/51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Oct. 9, 1951 | NAME OF CEMETERY OR CREMATORY Laurel Hill Cem. | LOCATION (City, town, or county) (State) Moscow, Maryland

DATE REC'D BY LOCAL REGISTRAR Oct 8, 1951 | REGISTRAR'S SIGNATURE Mrs Jean C. Kelly

24. FUNERAL DIRECTOR Ellsworth S. Boal ADDRESS Westernport, Md.

BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 13 mos.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 406 Fayette St.

3. NAME OF DECEASED (Type or Print): (First) Mary (MAE) (Middle) T. (Last) Keller

4. DATE OF DEATH: (Month) 10 (Day) 11 (Year) 19 51

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: June 11 1875

9. AGE last birthday: 76 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: ANTIQUES

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Henry Keller

14. MOTHER'S MAIDEN NAME: Margaret Zimmerman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-0225

17. INFORMANT AND ADDRESS: MRS Wm. L Keller Cumberland

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Atelectasis Right Lung — Interval Between Onset and Death: 3 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

517.0 114 —

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 23, 1950, to Oct. 11, 1951, that I last saw the deceased alive on Oct. 10, 1951, and that death occurred at 2:15 a.m., from the causes and on the date stated above.

SIGNATURE: Albert J. Jones | (Degree or title) M.D. | ADDRESS 110 S. Centre St. | DATE SIGNED Oct. 11, 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct 13 51 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cem | LOCATION (City, town or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Oct. 12, 1951 | REGISTRAR'S SIGNATURE: Wirtz R. Wantz, M.D. | 24. FUNERAL DIRECTOR: Toms Stem Inc | ADDRESS: Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

09142

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 4 Hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Dead on arrival at the Memorial Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 1117 Kentucky Ave.

3. NAME OF DECEASED (Type or Print): (First) Kenneth (Middle) Harrison (Last) Kennedy
4. DATE OF DEATH: (Month) Oct. (Day) 1 (Year) 1951

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 8-1899
9. AGE last birthday: 52 yrs. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinest helper, Diseal
10b. KIND OF BUSINESS OR INDUSTRY: Dept. B&O.R.Ry.
11. BIRTHPLACE (State or foreign country): Hyndman, Pa.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Kennedy
14. MOTHER'S MAIDEN NAME: Anna Wertz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
16. SOCIAL SECURITY NO.: 214-05-9176
17. INFORMANT AND ADDRESS: wife) Mattie Kennedy Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | Interval Between Onset and Death |
|---|---|---|---|
| Immediate cause | (a) | Coronary thrombosis | at once |
| 420.1 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | Coronary sclerosis | ? |
| | (c) | | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ✱, Inspection ✱, Inquiry ✱ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✱, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland, Md. Oct. 1-1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10/4/51
NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 4, 1951
REGISTRAR'S SIGNATURE: Walter R. Frantz M.D.
24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: Cumberland, Md.

RECEIVED
U. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nikep
MARYLAND — LENGTH OF STAY in this place: 25 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Alleg ny
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nikep
STREET ADDRESS (If rural, give location) State Road

3. NAME OF DECEASED (Type or Print): (First) Blanche (Middle) (Last) Kiddy

4. DATE OF DEATH: (Month) Oct (Day) 8 (Year) 19 51

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 4/3/1898

9. AGE last birthday: 53 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Archibald Russell

14. MOTHER'S MAIDEN NAME: Fannie Broadwater

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Harold Kiddy, Nikep, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 1 day |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Bronchial Pneumonia | 3 day |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/5, 1957, to 10/8, 1957, that I last saw the deceased alive on 10/7, 1957 and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE: Paul Eugene Frye (Degree or title) M.D. ADDRESS: Lonaconing, Md. DATE SIGNED: 10/9/57

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 10/11/51

NAME OF CEMETERY OR CREMATORY: Laurel Hill Cem.

LOCATION (City, town, or county) (State): Moscow, Md.

DATE REC'D BY LOCAL REG.: 10-10-57

REGISTRAR'S SIGNATURE: Jennette M Boal

24. FUNERAL DIRECTOR: Ellsworth S. Boal

ADDRESS: Westernport, Md.

DR. RICHARD WILLIAMS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

6540

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): 97 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 247 MASSACHUSETTS AVENUE

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) A. (Last) KNOTTS

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1951

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 5/13/1897

9. AGE last birthday: 54 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET RADIO REPAIRMAN

10b. KIND OF BUSINESS OR INDUSTRY: ELETRIC Co

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: STEPHEN KNOTTS

14. MOTHER'S MAIDEN NAME: MARY ETTA TAYLOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-5546

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Hypertension - Cerebral Hemorrhage | 3 mos. |
| 331X 332 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | |
| | (c) — | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1/51 19..... to 10/22/51, 19....., that I last saw the deceased alive on 10/22/51 19....., and that death occurred at 4:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H. Williams, M.D. ADDRESS: Cumberland Md DATE SIGNED: 10/23/51

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE THEREOF: 10-25-51

NAME OF CEMETERY OR CREMATORY: MOUNT HERMAN

LOCATION (City, town, or county): CUMBERLAND (State): MD.

DATE REC'D BY LOCAL REG. Oct. 23, 1951

REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: James F. Angelli ADDRESS: Cumberland Md.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany; MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 40 years | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Maryland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible] | STREET ADDRESS (If rural, give location) [illegible] |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Mary | Clive | Koch | Oct | 25 | 19 51 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | [illegible] | January 1 | [illegible] yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | [illegible], Maryland. | US |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William F. Wilson | Evelyn Lavin |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No / No | None | Charles F. Wilson, Hillcrest, Md. |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Coronary Thrombosis — 30 min.

4201 / 932 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Myocarditis — 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from Sept. 19 50 to Oct. 25 19 51, that I last saw the deceased alive on Oct. 25, 19 51, and that death occurred at 8:A. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Chas. F. Jones | M.D. | Cumberland | 10/27/51 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-28-51 | Rose Hill Cemetery | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 27, 1951 | Wm. L. Hanby M.D. | Louis P. Scarelli, Cumberland, Md. | |

VS: A15

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 14 S Lee St.

3. NAME OF DECEASED (Type or Print): (First) Aaron (Middle) (Last) Lazarus

4. DATE OF DEATH (Month) Oct (Day) 16 (Year) 1951

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH MAY 2 1862

9. AGE Last birthday 89 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN

10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE

11. BIRTHPLACE (State or foreign country) Lithuania

12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME — LAZARUS

14. MOTHER'S MAIDEN NAME DORA FEINSTEIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS MARK LAZARUS Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Heart Disease | 1 hour |
| 420.1 / 8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary Thrombosis Left | 1 week |
| | (c) Generalized arteriosclerosis | years |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 8, 1951, to Oct 16, 1951, that I last saw the deceased alive on Oct 16, 1951, and that death occurred at 1:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

B M Schindler MD 41 Greene St Cumberland Md 10/17/51

23. BURIAL, CREMATION, REMOVAL (Specify) Buried | DATE THEREOF Oct 18 51 | NAME OF CEMETERY OR CREMATORY East View Cem | LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Oct. 18, 1951 | REGISTRAR'S SIGNATURE Walter K. Hartz, M.D. | 24. FUNERAL DIRECTOR Louis Stein Sons ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11-2-ams

VS. A15

[illegible] V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

3017

C 147

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY ALLEGANY | MARYLAND |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 104 DAYS |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | |
| 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND | COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | |
| STREET ADDRESS (If rural, give location) 210 CHARLES STREET | |

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | WARD | | LEASURE | | 10 | 23 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | SEPARATED | 8/4/1880 | 71 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Retired Farmer | Farm owner | MARYLAND Allegany Co., Cumberland, | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| JOHN T. LEASURE | CATHERINE BELL |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|---|
| No | | None | MEMORIAL HOSPITAL, |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Bronchogenic Carcinoma Lung | 3 yrs. |
| 162 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 47d | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from August, 1949, to October, 1951, that I last saw the deceased alive on Oct. 23, 1951, and that death occurred at 4:00 P. m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Edward [illegible] Jerman M.D. | Cumberland Md. | |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/25/51 | Zion Memorial Cem. | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 25, 1951 | Winter R. Hantz, M.D. | H. Wayne George | Cumberland, Md. |

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05146

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D.#1 Frostburg, Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) T. (Last) Martin

4. DATE OF DEATH: (Month) 10 (Day) 25 (Year) 1951

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 3-25-86

9. AGE last birthday: 65 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles W. Livingstone

14. MOTHER'S MAIDEN NAME: Mary Dick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mr. John Martin, Husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial failure — Interval between onset and death: 3 Two

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) General arteriosclerosis — 5 yrs.

450.0

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 14, 1951, to Oct. 26, 1951, that I last saw the deceased alive on Oct. 24, 1951, and that death occurred at 7:42 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M.D. 110 S. Centre St. Oct. 29, 1951

23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF Oct 28, 1951 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. Oct 31 1951 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

09345

Reg. Dist. No. 4

PLEASE WRITE PLAINLY. WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 40 Minutes; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 722 Maryland Ave.

3. NAME OF DECEASED (Type or Print): (First) Elsie (Middle) V. (Last) Mc Bride

4. DATE OF DEATH: (Month) Oct. (Day) 18 (Year) 1951

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: May 25-1884

9. AGE last birthday: 67 yrs. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): near Three Churches, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elick Kidwell

14. MOTHER'S MAIDEN NAME: Sarah Moreland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS: daughter) Nellie Bowers, Cumberland, Md.

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronaty sclerosis also had | about 1 1/2 hrs |
| 420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 61 | (b) Diabetes Mellitus | about 5 yrs. |
| | (c) | |

20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

21a. DATE OF OPERATION

21b. MAJOR FINDINGS OF OPERATION

22. AUTOPSY? Yes ☐ No ☒

23. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

24. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V. Deming M.D. | H.V. Deming M.D. | Cumberland, Md. | Oct-18-1951 |

| 25. BURIAL, CREMATION OR REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/20/1951 | Mt. Olivet Cemetery | Glamsville W Va |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 26. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 20, 1951 | Walter R. Frantz, M.D. | Wm. H. Kight | Cumberland Md. |

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

09454

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (In this place) 3 HRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA — COUNTY HAMPSHIRE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROMNEY
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) CLIFFORD (Middle) ERNEST (Last) McDONALD
4. DATE OF DEATH: (Month) OCTOBER (Day) 13, (Year) 19 51

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: SEPT. 29, 77
9. AGE last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK - J.BRADY THOMPSON
10b. KIND OF BUSINESS OR INDUSTRY: HARDWARE
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS McDONALD
14. MOTHER'S MAIDEN NAME: MELLISA POWNALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 213 24 6127
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) SHOCK, CONTUSION OF BRAIN, COMPOUND FRACTURE

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) FIBULA & TIBIA OF LEFT LEG AND FRACT. PELVIS

170.2

(c) 5 HOURS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: CHRONIC MYOCARDITIS? — ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH
PLACE (Home, farm, factory, street, office building, etc.) OF INJURY ROUTE #50
(CITY OR TOWN) ROMNEY (COUNTY) HAMPSHIRE (STATE) W.VA.
TIME OF INJURY (Month) (Day) (Year) (Hour) OCT. 13, 1951 5:00 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? WALKING CROSS ROAD STRUCK BY TRUCK

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.W. DEMING, MD. — ADDRESS: CUMBERLAND, MD. — DATE SIGNED: OCT. 13, 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 16, 1951 — NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery — LOCATION (City, town, or county) (State): Romney W.Va.

DATE REC'D BY LOCAL REG.: Oct. 15, 1951 — REGISTRAR'S SIGNATURE: Walter R. Trantz, M.D. — 24. FUNERAL DIRECTOR: Meryl Combs. — ADDRESS: Romney, W.Va.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

OCT
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

09453
Reg. Dist. No. 02

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural Flintstone; LENGTH OF STAY (in this place): MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D.Star Route

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural) Flintstone; STREET ADDRESS (If rural, give location): R.F.D. Star route.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Alva | Bruce | Mc Elfish | Oct. | 17 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Widower | Feb.23-1888 | 63 yrs. | . | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired farmer | Own Farm | rural) Flintstone,Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Campbell Mc Elfish | Louisa J. Perdew |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | 544-28-8383 | Health Certificate |

### 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | ? |
| | (c) | |

42.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection* ☐, Inquiry* ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V.Deming M.D. H.V. Deming M.D. | | Cumberland,Md. | Oct.18-1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 21, 1951 | I.O.O.F. | Near Flintstone, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct 20, 1951 | Nina L. Bender | John J. Hafer, | Cumberland, Md. |

VS-A15A

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09452

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 1 hour
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital, Cumberland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rds Cumberland, Rural
STREET ADDRESS (If rural give location) Rt. #4, Bruce Hollow Road

3. NAME OF DECEASED (Type or Print): (First) Barbara (Middle) Ray (Last) McGraw
4. DATE OF DEATH: (Month) 10 (Day) 14 (Year) 1951
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 10-14-51
9. AGE last birthday: 1 hour yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min. 1 / 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jeremiah Thomas McGraw
14. MOTHER'S MAIDEN NAME: Catherine Rapp
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: —
17. INFORMANT: mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) premature separation of placenta — 2 days

761.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

160 C (c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-14-, 1951, to 10-14-, 1951, that I last saw the deceased alive on 10-14-, 1951, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm. [illegible] MD — ADDRESS 57 Greene St. — DATE SIGNED 10-15-51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10-17-1951 — NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery — LOCATION (City, town, or county) Cumberland, — (State) Md.

DATE REC'D BY LOCAL REG. Oct. 17, 1951 — REGISTRAR'S SIGNATURE Walter L. Rantz, M.D. — 24. FUNERAL DIRECTOR Wm. H. Right — ADDRESS Cumberland, Md

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09151

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY. WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (in this place): 5 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: West Virginia — COUNTY: Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bayard
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Arthur (Middle) Melchoir (Last) Miller

4. DATE OF DEATH: (Month) Oct. (Day) 23 (Year) 1951

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: March-14-1876

9. AGE last birthday: 75 yrs. | If under 1 year: Months / Days | If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): miner

10b. KIND OF BUSINESS OR INDUSTRY: Digging coal

11. BIRTHPLACE (State or foreign country): Barbour Co. W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Miller

14. MOTHER'S MAIDEN NAME: Louisa Streets

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Bayard, W.Va. wife) Missouri Everts Miller

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Intracranial hemorrhage due to a fracture | 8 hrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) of the skull, right temporal region. | |
| 186a | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS ✓ PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home

(CITY OR TOWN): Bayard (COUNTY): Grant (STATE): W.Va.

TIME (Month) (Day) (Year) (Hour) OF INJURY: Oct 23/51 A. 3.15 m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Made a mis-step & fell head first down the stairs.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V.Deming M.D. | H.V. Deming M.D. | Cumberland, Md. | Oct 23-1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 27, 1951 | Bayard Cemetery | Bayard, West Virginia |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 23, 1951 | Winter K. Dantz, M.D. | J.D.D. Duncan, Thomas, West Virginia | |

VS-A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09450

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (in this place) ½ Hr.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Frostburg; STREET ADDRESS (If rural, give location) Land Spring

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Bernard (Last) Minnick

4. DATE OF DEATH: (Month) 10 (Day) 13 (Year) 1951

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 4-30-1951

9. AGE last birthday: ----- yrs. If under 1 year: Months 5, Days 13; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Robert Jerome Minnick

14. MOTHER'S MAIDEN NAME: Isabell Louise Caton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Isabell L.Caton, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Broncho-Pneumonia — Interval Between Onset and Death: 20 hrs.

491X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

107 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-12, 1951, to 10-13, 1951, that I last saw the deceased alive on 10-13, 1951, and that death occurred at 4:10 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

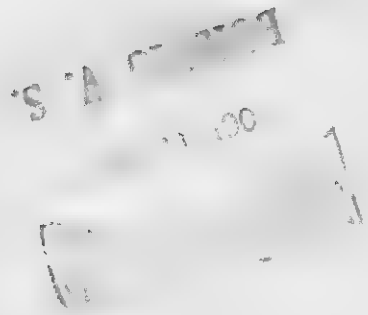
J. C. Diehl M.D. Frostburg, Md. 10/15/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 10-16-1951; NAME OF CEMETERY OR CREMATORY: St. Michaels; LOCATION (City, town, or county) (State): Frostburg, Md,

DATE REC'D BY LOCAL REG. 10-15-51; REGISTRAR'S SIGNATURE: Mrs Nancy A Roe

24. FUNERAL DIRECTOR ADDRESS: Joseph R. Durst, Frostburg, Md.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland; LENGTH OF STAY (in this place) 9 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS "M" St. Potomac Park

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland; STREET ADDRESS (If rural, give location) "M" St. Potomac Park

3. NAME OF DECEASED (Type or Print): (First) ELMA; (Middle); (Last) MONNETT

4. DATE OF DEATH: (Month) Oct. (Day) 23, (Year) 1951

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 28, 1892

9. AGE last birthday: 58 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lawrence Beal

14. MOTHER'S MAIDEN NAME: Mollie Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Alex Monnett, Rt. 6, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval between onset and death: ?

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

94a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1951, to 10/23, 1951, that I last saw the deceased alive on 10/23, 1951 and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Geo. W. Brown M.D. Cumberland Md 10/24/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 10/26/1951; NAME OF CEMETERY OR CREMATORY: Monnett & Lechliter Cemetery; LOCATION (City, town, or county) (State): Route 1, Ridgeley, W.Va.

DATE REC'D BY LOCAL REG. 10/25/51; REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

09458

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route 28 in auto in route to the; LENGTH OF STAY (In this place): ; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital at Frostburg, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: P.O. Westernport; STREET ADDRESS (If rural, give location): R.F.D. Franklin, Md.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) William (Last) Moreland

4. DATE OF DEATH: (Month) Oct. (Day) 8 (Year) 1951

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: June 6-1925

9. AGE last birthday: 26 yrs. If under 1 year: Months / Days / If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver for the Cross Coal Co.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Keyser, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Moreland

14. MOTHER'S MAIDEN NAME: Ollie Graham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes, navy (If yes, give war or dates of service) W.W.2

16. SOCIAL SECURITY NO. 236-20-9585

17. INFORMANT AND ADDRESS: (wife) Mrs. J.W. Moreland, Franklin, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Intracranial hemorrhage due to a fractured

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) skull, also had fractured left clavical &
(c) left malar bone.

INTERVAL BETWEEN ONSET AND DEATH: about 10 minutes

X1
170c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY* OR CONTRIBUTING* CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway near (CITY OR TOWN) Pekin (COUNTY) Allegany (STATE) Md.

TIME OF INJURY (Month) Oct. (Day) 8/51 (Year) (Hour) 8:40 a.m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Auto & a C & W. Bus going in opposite direction, crashed.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. H.V. Deming M.D. ADDRESS: Cumberland, Md. DATE SIGNED: Oct. 8-1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF: 10/11/51 NAME OF CEMETERY OR CREMATORY: Queens Point LOCATION (City, town, or county): Keyser (State) W. Va.

DATE REC'D BY LOCAL REG. 10-10-51 REGISTRAR'S SIGNATURE: Pauline M. Boat Nancy H. Roe

24. FUNERAL DIRECTOR: Ellsworth S. Boat ADDRESS: Westernport

DR. RAW

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND MD — LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 313 Pennsylvania Avenue

3. NAME OF DECEASED (Type or Print): (First) HOWARD (Middle) R. (Last) MORRISON
4. DATE OF DEATH: (Month) OCT. (Day) 6 (Year) 1951
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: OCT. 8 1908
9. AGE last birthday: 42 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: WILLIAM MORRISON
14. MOTHER'S MAIDEN NAME: EVA ROSS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-05-6174
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Multiple sclerosis with paralytic ileus and intestinal obstruction — 10 days
345X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) multiple sclerosis with quandraplegia — 8 yrs.
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 4, 1951, to Oct 6, 1951, that I last saw the deceased alive on Oct 6, 1951, and that death occurred at 9 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Wilbur Fowler M. D. Cumberland Md Oct 6. 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10-8-1951
NAME OF CEMETERY OR CREMATORY: Burlington Cemetery
LOCATION (City, town, or county) (State): Burlington Iowa

DATE REC'D BY LOCAL REG.: Oct. 7, 1951
REGISTRAR'S SIGNATURE: Winter L. Lantz M.D.
24. FUNERAL DIRECTOR: W. H. Kight, ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

DR. ROTH

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND MD.; LENGTH OF STAY (in this place) 24 DYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ELLERSLIE; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) HARRY (Middle) R. (Last) PORTER

4. DATE OF DEATH: (Month) OCT. (Day) 22 (Year) 1951

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: OCT. 6, 1878

9. AGE Last birthday: 73 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Conductor

10b. KIND OF BUSINESS OR INDUSTRY: PRR

11. BIRTHPLACE (State or foreign country): PENNA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: NORMAN PORTER

14. MOTHER'S MAIDEN NAME: SARAH STAIR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 716 10 5693

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary tuberculosis — Interval between onset and death: Unknown

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 13 h

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 24, 1951, to Oct 22 1951, that I last saw the deceased alive on Oct 21, 1951, and that death occurred at 9:05 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Peter Robb Rod, M.D. 202 Virginia Ave. Cumberland Md. 10/22/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 10.25.51 | NAME OF CEMETERY OR CREMATORY: Palo Alto Cemetery | LOCATION (City, town, or county) (State): Hyndman, Pa. Rural

DATE REC'D BY LOCAL REG.: Oct. 23, 1951 | REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Harvey H. Zeigler, Hyndman, Pa.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural - Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
STREET ADDRESS (If rural, give location):

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| ROSEMARY | | PORTER | Oct. | 31, | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widowed | 10-18-1882 | 69 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Porter | Sarah Matthews |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | none | Charles Porter, Eckhart, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause (a) | Coronary occlusion | sudden |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) | Coronary Sclerosis | 1 yr. |
| (c) | Arteri Sclerosis | ? |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 1950, 19..., to Oct 31, 1951, that I last saw the deceased alive on Oct 22, 1951, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| W D McClane M D | | Frostburg Md | Oct 31 1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-2-51 | Eckhart Cemetery | Eckhart, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11-3-51 | Mrs Nancy N Fox | J. R. Durst, | Frostburg, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg | LENGTH OF STAY (in this place) 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 34 Broadway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 34 Broadway

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Ethan | A. | Pearl | Oct. | 8 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | July 26-1872 | 79 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Own business | Frahuntsman, Md. | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Pearl | Martha Baldwin |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| None | None | Mrs Earl Kerr, 34 Broadway, Frostburg, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Hemorrhage | 12 hrs |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension | Several years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Oct 3, 1951, to Oct 8, 1951, that I last saw the deceased alive on Oct 8, 1951, and that death occurred at 8 30 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| W McLane | MD | Frostburg Md | 10-10-51 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 10-11-1951 | Frostburg Memorial | Frostburg | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-11-51 | Mrs Nancy K Roe | Jacob Dafler | Frostburg Md |

MARYLAND STATE DEPARTMENT OF HEALTH

09461

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6 Virginia Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 6 Virginia Ave.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| James | Samuel | Tight | Oct. | 26 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | widowed | July 12 1875 | 76 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired engineer | R. R. Co. | Baltimore Md | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Tight | Rebecca Wilson |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | 702-14-[illegible] | Sister Augusta Tight Cumberland Md. |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| Immediate cause (a) Coronary occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis | 1 week |
| (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus | about 2 yrs |

420.1
61

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| C. V. Deming M.D. | | Cumberland Md. | Oct. 29, 1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 29, 51 | Hill Crest | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 29, 1951 | Chester K. Hank, M.D. | C. W. McKee, Augusta, | West Virginia |

MARYLAND STATE DEPARTMENT OF HEALTH Dr. [illegible]lson

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; MARYLAND; LENGTH OF STAY (in this place): ; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 401 Spruce St

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; STREET ADDRESS (If rural, give location): 401 Spruce Street

3. NAME OF DECEASED (Type or Print): (First) COLLIN (Middle) THOMAS (Last) REEVES

4. DATE OF DEATH: (Month) October (Day) 27 (Year) 1951

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec 29, 1891

9. AGE last birthday: 59 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Westernport, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Reeves

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs C. [illegible] Reeves

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Acute Pulmonary Edema | 1 Day |
| 502.1 106 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic Bronchitis | 33 Years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gas Casualty in World War I — 33 Years

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 27, 1951, to Oct 27, 1951, that I last saw the deceased alive on Oct. 27, 1951, and that death occurred at 9:40 p m., from the causes and on the date stated above.

SIGNATURE: Paul R Wilson (Degree or title) M.D. ADDRESS: Piedmont, W.Va. DATE SIGNED: Oct. 29, 1951

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 30 October '51 | Philos Cemetery | Westernport, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct 30, 1951 | Mrs Jean C. Kelly | E. S. Boal, | Westernport, Maryland |

RECEIVED
NOV 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FROSTBURG; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS MINERS HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FROSTBURG; STREET ADDRESS (If rural, give location) RT. 2, FROSTBURG

3. NAME OF DECEASED (Type or Print): (First) EDWARD (Middle) (Last) REPHANN

4. DATE OF DEATH: (Month) Oct. (Day) 30, (Year) 1951

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 2-28-1891

9. AGE last birthday: 60 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired miner

10b. KIND OF BUSINESS OR INDUSTRY: coal mines

11. BIRTHPLACE (State or foreign country): ECKHART, MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CONRAD REPHANN

14. MOTHER'S MAIDEN NAME: CATHERINE LANCASTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW 1

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Edw. Rephann, Rt. 2, Frostburg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) cerebral hemorrhage | 4 hours |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) arteriosclerotic heart disease | 5 years |
| | (c) Hypertension | 5 years |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. multiple sclerosis — 10 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

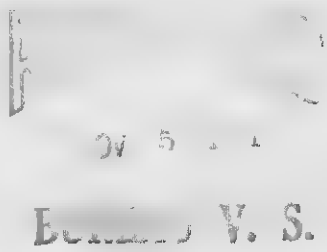
22. I hereby certify that I attended the deceased from 5-10, 1951, to 10-30, 1951, that I last saw the deceased alive on 10-30, 1951, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

SIGNATURE: L Wolferman (Degree or title) M.D ADDRESS Frostburg Md. DATE SIGNED 11-1-51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 11-2-51; NAME OF CEMETERY OR CREMATORY: Frostburg Mem'l Park; LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 11-3-51; REGISTRAR'S SIGNATURE: Dora Lewey H. Roe

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart; LENGTH OF STAY (In this place): life; HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart; STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) HENRY (Middle) (Last) REPHANN

4. DATE OF DEATH: (Month) Oct. (Day) 9, (Year) 1951

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: 10-3-1873

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retiredstationary engineer

10b. KIND OF BUSINESS OR INDUSTRY: Ice plant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Rephann

14. MOTHER'S MAIDEN NAME: Mary Lydinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-9872

17. INFORMANT AND ADDRESS: Donald Rephann, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | ? |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. V. Deming, M. D. H. V. Deming Cumberland, Md. Oct. 9 '51

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 10-11-51

NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

LOCATION (City, town, or county) (State): Eckhart, Md.

DATE REC'D BY LOCAL REG.: 10-11-51

REGISTRAR'S SIGNATURE: Mrs Nancy H. Poe

24. FUNERAL DIRECTOR ADDRESS: J. R. Durst, Frostburg, Md.

VS. A15A

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS.A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place) 54 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 704 Bedford St. | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 704 Bedford St. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| George | William | Ridgway | Oct | 10 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | Jan. 30, 1871 | 80 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Machinist-Retired | B & O Railroad | Keyser, W. Va. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Kenney Ridgway | Margaret Ellen Giffen |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|---|
| No | | 705-09-9860 | Charles O. Ridgway, Cumberland, Md. |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | Hours |
| 420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 944 | (b) Arteriosclerosis & Hypertension | Years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from Sept., 1951, to Oct. 10, 1951, that I last saw the deceased alive on Oct. 9, 1951, and that death occurred at 9:30 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Clay R. Lantz | M.D. | Cumberland | 10/12/51 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Oct. 12, 1951 | Hillcrest Burial Park | Cumberland, | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 12, 1951 | Walter L. Lantz, M.D. | John J. Hafer, | Cumberland, Md. |

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

**1. PLACE OF DEATH**
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 13 Willison Place

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 13 Willison Place

**3. NAME OF DECEASED** (Type or Print): (First) Harry (Middle) Leo (Last) Rodney

**4. DATE OF DEATH**: (Month) Oct. (Day) 5 (Year) 1951

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Single

**8. DATE OF BIRTH**: Dec. 16, 1880

**9. AGE last birthday**: 71 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Kitchen employee

**10b. KIND OF BUSINESS OR INDUSTRY**: Hospital

**11. BIRTHPLACE** (State or foreign country): Orleans, Md.

**12. CITIZEN OF WHAT COUNTRY**: USA

**13. FATHER'S NAME**: James O. Rodney

**14. MOTHER'S MAIDEN NAME**: Annie M. Wise

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service): No

**16. SOCIAL SECURITY NO.**: 220-10-0004

**17. INFORMANT AND ADDRESS**: Emily M. Rodney, 13 Willison Place.

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

Immediate cause (a) Myocarditis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Bronchitis

(c)

INTERVAL BETWEEN ONSET AND DEATH

**II. OTHER SIGNIFICANT CONDITIONS** Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION** | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) | PLACE (Home, farm, factory, street, OF INJURY office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 4, 1951, to Oct 5, 1951, that I last saw the deceased alive on Oct 5, 1951, and that death occurred at 7:55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): L. Wallace Ly | ADDRESS: 49 Green St Cumberland Md | DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct. 8, 1951 | NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 8, 1951 | REGISTRAR'S SIGNATURE: Winter L. Mantz, M.D. | 24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Md. | ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

09467

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 2 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Wilson 13 Wilson Place

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Wilson 13 Wilson Place

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Samuel | R. | Rodney | Oct. | 31 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | June 26-1886 | 65 yrs. | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James O. Rodney
14. MOTHER'S MAIDEN NAME: Annie W. Wise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Ellen E Rodney (sister)

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Bronchogenic carcinoma of the right lung — ?

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) with an abscess.
(c)

62X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ✱, Inspection ✱, Inquiry ✱ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✱, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V. Deming M.D. | H.V. Deming M.D. | Cumberland, Md. | Nov. 1-1951 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 2, 1951 | St. Patricks | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Nov. 1, 1951 | Wintes L. Lantz, M.D. | John J. Hafer, | Cumberland, Md. |

VS. A15A

Within corporate limits: DR W.F. WMS. Marker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

05468

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 10 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MIDLAND; STREET ADDRESS (If rural, give location) Church Street

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) E. (Last) ROSS

4. DATE OF DEATH: (Month) OCT. (Day) 28 (Year) 1951

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: NOV. 13 1883

9. AGE last birthday: 67 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED NAVY OFFICER

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES ROSS

14. MOTHER'S MAIDEN NAME: CATHERINE A. HUMBLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hepato-renal failure — Interval between onset and death: 3 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Gangrenous perforated appendicitis & abscess & intestinal obstruction — 6 days before

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity - Hypertension (mod.)

19a. DATE OF OPERATION: Oct 22/51

19b. MAJOR FINDINGS OF OPERATION: Intest. obstr. due to appendiceal abscess

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF INJURY office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to 10-28, 19 51, that I last saw the deceased alive on 10-28, 19 51, and that death occurred at 10:43P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

C. Mirren M.D. Cumberland Md 10/29/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Oct. 31 1951

NAME OF CEMETERY OR CREMATORY: Fostburg Memorial Park

LOCATION (City, town, or county) (State): Fostburg, Maryland

DATE REC'D BY LOCAL REG.: Oct. 30, 1951

REGISTRAR'S SIGNATURE: Wister K. Bantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: M. Eichhorn, Lonaconing, "

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

03469

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 13 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 508 Marshall St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 508 Marshall St.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Mary | Kathryn | Rowan | Oct. | 4 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | married | July 22-1903 | 48 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Lonaconing, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Bernard D. Keating | Mary Ellen Goldworthy |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | none | William Rowan (husband) |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion due to — about 5 min.

420.1 94a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V. Deming M.D. | H.V. Deming M.D. | Cumberland, Md. | Oct. 4-1951 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Oct. 6, 1951 | St. Patrick's Cemetery | Cumberland | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 5, 1951 | Wintes R. Hartz, M.D. | John J. Hafer, Cumberland, Md. | |

VS. A18A

BUREAU V. S.

DR. W.F.WMS.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09470

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; CUMBERLAND; MARYLAND; LENGTH OF STAY (in this place) 1 DAY; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; STREET ADDRESS (If rural, give location) 912 PIEDMONT AVENUE

3. NAME OF DECEASED (Type or Print): (First) EMORY (Middle) (Last) RUNION

4. DATE OF DEATH: (Month) OCT. (Day) 21 (Year) 51

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: MARCH 18 80

9. AGE last birthday: 65 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SHOVEL-OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: Construction Co [redacted]

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ADDISON RUNION

14. MOTHER'S MAIDEN NAME: SALLY BOBO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: 714-05-7233

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio Vascular Renal

442 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Disease (Uremia)

131a (c)

INTERVAL BETWEEN ONSET AND DEATH: (a) One (b) Month

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-10, 1949, to 10-21, 1951, that I last saw the deceased alive on 10-21, 1951, and that death occurred at 11:20 m. P, from the causes and on the date stated above.

SIGNATURE: W. L. Williams (Degree or title) MD ADDRESS: Cumberland DATE SIGNED: 10-22-51

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE THEREOF: Oct 24 1951 | NAME OF CEMETERY OR CREMATORY: Ft Ashby Cem. | LOCATION (City, town, or county) (State): Ft Ashby W Va

DATE REC'D BY LOCAL REG. Oct. 24, 1951 | REGISTRAR'S SIGNATURE: Winter K. Hanby, M.D. | 24. FUNERAL DIRECTOR: Louis Stein Inc. | ADDRESS: Cumberland Md.

Within corporate limits

Within

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 210 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Ellen (Last) Ryland
4. DATE OF DEATH (Month) Oct. (Day) 8, (Year) 1951

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH: 5-11-1866
9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Winchester, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Lillis
14. MOTHER'S MAIDEN NAME: Mary Lillis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Harold Senkbeil Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | Interval Between Onset and Death |
|---|---|---|---|
| Immediate cause | (a) | Cardiac Failure | 1 Day |
| 151 Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last 162 | (b) | Cancer of Stomach | 2 years |
| | (c) | | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 19..., to Oct 8, 19 51, that I last saw the deceased alive on Oct 8, 1951, and that death occurred at 7:45 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Samuel G Wiseman and 596 Greene St Cumberland, Md Oct 9, 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10-11-1951
NAME OF CEMETERY OR CREMATORY: St. Patricks Cem.
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 9, 1951
REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
MARYLAND
LENGTH OF STAY (In this place) 45 min
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural give location) 61 Wright ST

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Boy (Last) Sgaggero

4. DATE OF DEATH (Month) Oct (Day) 5 (Year) 1951

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S | 8. DATE OF BIRTH 10/5/51 | 9. AGE last birthday — yrs. | If under 1 year: Months — Days — | If under 24 hrs.: Hours — Min. 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Frostburg Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Vitto Sgaggero
14. MOTHER'S MAIDEN NAME Philomena DiBonno

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Philomena Sgaggero

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity — Interval between onset and death: 45 min

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or coodition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/5-, 1951, to 10/5, 1951, that I last saw the deceased alive on 10/5-, 1951, and that death occurred at 330 A m., from the causes and on the date stated above.

SIGNATURE Hilda Auswaltz | (Degree or title) M.D. | ADDRESS Frostburg Md | DATE SIGNED 10/5/51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 10-5-1951 | NAME OF CEMETERY OR CREMATORY St. Michaels Cem. | LOCATION (City, town, or county) Frostburg | (State) Md

DATE REC'D BY LOCAL REG. 10-5-51 | REGISTRAR'S SIGNATURE Mrs. Dawey N. Roe | 24. FUNERAL DIRECTOR Jacob Hafer | ADDRESS Frostburg, Md

200051 284 02 C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

OCT
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 1 MO. 3
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 207 MARYLAND AVE.

3. NAME OF DECEASED (Type or Print): (First) BABY BOY (Middle) (Last) EAGLE
4. DATE OF DEATH: (Month) OCT. (Day) 16, (Year) 1951

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: 10/16/1951
9. AGE last birthday: yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours 1 | Min. 12

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: LEROY SPRANGLE
14. MOTHER'S MAIDEN NAME: MARGARET H. BLYTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fetal Monster

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 750X 157m

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/16, 1951, to 10/16, 1951, that I last saw the deceased alive on 10/16, 1951, and that death occurred at 3:55 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
W. Royce Hodges, M.D. | Cumberland, Md. | 10/16/51

23. BURIAL, CREMATION, REMOVAL (Specify): CREMATION | DATE THEREOF: 10/17/51 | NAME OF CEMETERY OR CREMATORY: MEMORIAL HOSPITAL | LOCATION (City, town, or county) (State): CUMBERLAND, MD.

DATE REC'D BY LOCAL REG. Oct. 17, 1951 | REGISTRAR'S SIGNATURE: Winter K. Saantz, M.D. | 24. FUNERAL DIRECTOR: Memorial Hosp. | ADDRESS: Cumberland, Md.

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 1 day; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 417 Valley St.

3. NAME OF DECEASED (Type or Print): (First) William; (Middle) A.; (Last) Stitcher

4. DATE OF DEATH: (Month) Oct; (Day) 21; (Year) 1951

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED: Widowed

8. DATE OF BIRTH: July 17 1881

9. AGE last birthday: 70 yrs.; If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Rail way

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Stitcher

14. MOTHER'S MAIDEN NAME: Caroline Becker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 205-09-9873

17. INFORMANT AND ADDRESS: John R Stitcher, Cumb'd Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchial Pneumonia

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic myocarditis.

(c) Cerebro sclerosis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/18, 1951, to 10/22, 1951, that I last saw the deceased alive on 10/22, 1951, and that death occurred at 6.50 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Lee N Rozumalski Cumberland Md 10-24-51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 10-24-51

NAME OF CEMETERY OR CREMATORY St. Peter + Paul Cem

LOCATION (City, town, or county) (State) Cumberland Md

DATE REC'D BY LOCAL REG. Oct. 23, 1951

REGISTRAR'S SIGNATURE Walter K. Hartz, M.D.

NAME OF FUNERAL DIRECTOR Thomas Stem Inc

ADDRESS Cumberland Md

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

09475

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 4 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Constitution Park (Cumberland)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Constitution Park. (Cumberland)

3. NAME OF DECEASED (Type or Print): (First) Mollie (Middle) B. (Last) Stubblefield
4. DATE OF DEATH: (Month) Oct. (Day) 20 (Year) 1951

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: Feb. 7-1866
9. AGE last birthday: 85 yrs. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Lantz Mill, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Jackson
14. MOTHER'S MAIDEN NAME: Lydia Ann Coffelt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY No.: none
17. INFORMANT AND ADDRESS: daughter) Mrs. Robt. R. Golden, City

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute cardiac failure due to — at once

450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis & senility. — ?

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H. V. Deming M.D. H. V. Deming M.D. Cumberland, Md. Oct. 22-1951

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Oct. 23 1951 | NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem. | LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REG. Oct. 23, 1951 | REGISTRAR'S SIGNATURE Winter R. Monk, M.D. | 24. FUNERAL DIRECTOR Louis Stein Inc. | ADDRESS Cumb. Md.

VS. A15A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

(5-76)

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 217 Glenn St.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Nora | Hannah | Tunney | October | 6 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Widowed | March 5, 1870 | 81 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Housewife | Own home | Louisville, Ky. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Michael Higgins | Margaret O'Toole |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | James L. Tunney, 217 Glenn St. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Cerebral Vascular Accident — 4 days

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

331 K

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from May, 1949, to Oct. 6, 1951, that I last saw the deceased alive on Oct. 5, 1951, and that death occurred at .....m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| George M. Simon | M.D. | Cumberland, Md | 10/8/51 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 8, 1951 | Sts. Peter & Paul's Cemetery | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 8, 1951 | Winter K. Dantz, M.D. | John J. Hafer | Cumberland, Md. |

Within corporate limits:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
MARYLAND
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Savage
STREET ADDRESS (If rural, give location) Church Hill

3. NAME OF DECEASED (Type or Print) (First) Annie (Middle) Louise (Last) Uhl

4. DATE OF DEATH (Month) Oct (Day) 11 (Year) 1951

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH July 10, 1871

9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country) Mt Savage Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Cornelius Geary

14. MOTHER'S MAIDEN NAME Elizabeth Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Loretta Uhl - Mt Savage Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Left Base Pneumonia — Interval between onset and death: 4 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Acute Nephritis — 6 days

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

INJURY

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 4, 1951, to Oct 11, 1951, that I last saw the deceased alive on Oct 11, 1951, and that death occurred at 7:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Alan E. Mann M.D. ADDRESS Cumberland Md DATE SIGNED Oct 12 51

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Oct. 14, 1951

NAME OF CEMETERY OR CREMATORY St Georges Episcopal Cem.

LOCATION (City, town, or county) (State) Mt Savage Md.

DATE REC'D BY LOCAL REG. Oct. 12, 1951

REGISTRAR'S SIGNATURE Winter L. Hantz, M.D.

FUNERAL DIRECTOR ADDRESS John J Hafer

Within corporate limits? DR. ELIASON

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

V8-A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 558 PATTERSON AVENUE

3. NAME OF DECEASED (Type or Print): (First) IRA (Middle) RANDALL (Last) UNGER

4. DATE OF DEATH: (Month) OCT. (Day) 13, (Year) 19 51

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: 10/2/1950

9. AGE last birthday: 1 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: IRA GLENN UNGER

14. MOTHER'S MAIDEN NAME: REBA L. SHIVES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Acute Respiratory Infection | 2 days. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Congenital Heart. | 11 mos |
| | (c) Cretinism | 11 mos |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11, 19 57, to 10-13, 19 51, that I last saw the deceased alive on 10-12, 19 51, and that death occurred at 3:17 A m., from the causes and on the date stated above.

SIGNATURE: A. H. Eliason (Degree or title) ADDRESS: 126 Union St. Cumberland Md DATE SIGNED: 10/13/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Oct 15 51

NAME OF CEMETERY OR CREMATORY: Episcopal Cemetery

LOCATION (City, town, or county) (State): Hancock Washington Md

DATE REC'D BY LOCAL REG.: Oct. 13, 1951

REGISTRAR'S SIGNATURE: Walter R. Dantz, M.D.

24. FUNERAL DIRECTOR: Charles R. East

ADDRESS: Hancock Md

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1031 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1031 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) Lorenzo (Middle) (Last) Valentine

4. DATE OF DEATH: (Month) Oct. (Day) 29 (Year) 1951

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 14, 1875

9. AGE last birthday: 76 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brakeman-Retired

10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad

11. BIRTHPLACE (State or foreign country): Cumberland, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Emanuel Valentine

14. MOTHER'S MAIDEN NAME: Sarah Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Mattie Valentine, 1031 Bedford, St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pyelonephritis — Interval between onset and death: 48 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Thrombosis — 4 days

(c) Cerebral Sclerosis — duration

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 27, 1951, to Oct. 29, 1951, that I last saw the deceased alive on Oct. 29, 1951, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE: [illegible] M.D. (Degree or title) ADDRESS: [illegible] DATE SIGNED: 30 Oct 51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Nov. 1, 1951 | NAME OF CEMETERY OR CREMATORY: Zion Memorial Park | LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Nov 1, 1951 | REGISTRAR'S SIGNATURE: Hunter R. Hanby, M.D.

24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The [illegible] is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

C9480

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS 111 S. Lee St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 111 S. Lee St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Priscilla (Last) Washington

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1951

5. SEX: F

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: Aug. 30, 1872

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Stewart

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Anna Paige, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypertensive C.V. Disease — Hemiplegia due to — Interval between onset and death: years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 19[illegible], to Oct. 6, 1951, that I last saw the deceased alive on Oct. 5, 1951, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

B. M. Schindler M.D. 41 Greene Cumberland Md. 10/6/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct. 8, 1951 | NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery | LOCATION (City, town, or county): Cumberland, (State): Md.

DATE REC'D BY LOCAL REG.: Oct. 8, 1951 | REGISTRAR'S SIGNATURE: Walter L. Hanly, M.D. | 24. FUNERAL DIRECTOR: John J. Hafer | ADDRESS: Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

C 5451

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 226 Emily St

3. NAME OF DECEASED (Type or Print): (First) Edward (Middle) (Last) Weisenmiller

4. DATE OF DEATH: (Month) Oct (Day) 10 (Year) 1951

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1/13/1878

9. AGE last birthday: 73 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinist

10b. KIND OF BUSINESS OR INDUSTRY: B&O R R

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Adam Weisenmiller

14. MOTHER'S MAIDEN NAME: Mary Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 1898-1899

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs Edward Dowlan Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Larynx

161 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

170 (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 7, 1951, to Oct 10, 1951, that I last saw the deceased alive on Oct 9, 1951, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Geo W Newman M.D Cumberland Md 10/10/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 10/12/51

NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG. Oct. 12, 1951

REGISTRAR'S SIGNATURE: Wm. K. Lantz, M.D.

24. FUNERAL DIRECTOR: Wm H. Light

ADDRESS: Cumberland Md

DR. W.F. WILLIAMS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STATE: MARYLAND
LENGTH OF STAY (in this place): 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: SHALLMAR
STREET ADDRESS (If rural, give location):

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| JOSEF | Roman | WESOLOSKY | OCTOBER | 27 | 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | MARCH 15 1871 | 80 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner
10b. KIND OF BUSINESS OR INDUSTRY: Digging Coal
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY: Poland

13. FATHER'S NAME: PETE WESOLOSKY
14. MOTHER'S MAIDEN NAME: ROSELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-14-4369
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cardio vascular renal | 3 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) disease (Uremia) | |
| | (c) Senility | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | | | |

22. I hereby certify that I attended the deceased from 10-25, 1951, to 10-27, 1951, that I last saw the deceased alive on 10-27, 1951, and that death occurred at 1:40P m., from the causes and on the date stated above.

SIGNATURE: W. F. Williams (Degree or title) M.D. ADDRESS: Cumberland DATE SIGNED: 10-27-51

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 30 1951 | Kalbaugh Cemetery | Elk Garden, W. Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 29, 1951 | Charles L. Beatty, M.D. | O. F. Sharpless | Blaine, W. Va. |

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

62383

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place) 1 Day; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location) State Street

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) (Last) Whitten

4. DATE OF DEATH: (Month) (Day) (Year) Oct, 2 1951

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan, 9, 1909

9. AGE last birthday: 42 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sanitary Man Worker

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Charles Whitten

14. MOTHER'S MAIDEN NAME: Minnie Whetson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Virginia Beeman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Myocardial degeneration | 1 yr. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Rheumatic Heart Disease | 1 yr. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at Work ☐ Not While At work ☐: HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/1, 1951, to 10/2, 1951, that I last saw the deceased alive on 10/2, 1951, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M Simmons M.D. 12 E Union St Cumberland Md. 10/3/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: Oct, 6, 1951; NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery; LOCATION (City, town, or county) (State): Lonaconing Md.

DATE REC'D BY LOCAL REG.: Oct. 6, 1951; REGISTRAR'S SIGNATURE: Walter L Frantz, M.D.

24. FUNERAL DIRECTOR: M. Eichhorn ADDRESS: Lonaconing, Md.

VS. A15

OCT 9 1954

BUREAU V. S.

Within corporate limits.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; HOSPITAL OR INSTITUTION OR STREET ADDRESS 375 Frederick St.; MARYLAND — LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 375 Frederick St.

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) Mae (Last) Williams

4. DATE OF DEATH: (Month) Oct (Day) 13 (Year) 1951

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: July 28 1874

9. AGE last birthday: 77 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Private Home

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicholas Francis

14. MOTHER'S MAIDEN NAME: Miranda Gibson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Bessie L. Williams, Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Vascular Accident | 8 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension Cardio-vascular Disease | 5 yrs |
| | (c) | |

44-X
932

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 14, 1949, to Oct. 13, 1951, that I last saw the deceased alive on Oct. 8, 1951, and that death occurred at 9 30 a m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Bond (Degree or title) M.D. ADDRESS: 110 S. Centre St. DATE SIGNED: Oct. 13, 1951

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Oct 15 '51

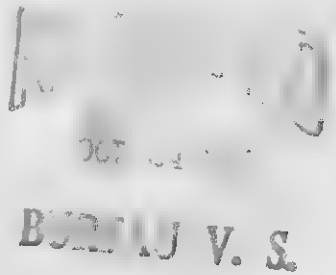
NAME OF CEMETERY OR CREMATORY: Rose Hill Cem

LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Oct. 15, 1951

REGISTRAR'S SIGNATURE: Walter L. Hank, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc ADDRESS: Cumberland



MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

65135

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (In this place) 3 min.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Eckhart; STREET ADDRESS (If rural, give location) P.O.,R.F.D.#1 Frostburg,Md.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| Melvin | Mc Kenzie | Wilt. | Oct. 13 1951 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | 1922 | 29 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Woodman | Sawmill | Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Silas Wilt | Mary Fazenbaker |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| yes W.W.2 | 184-18-2146 | Brother) Bruce Wilt, Eckhart, Md. |

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Exsanguination due to a 12 gauge shotgun | 1/2 hr/ |
| 119.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) wound in right thigh, femoral vessels servered and damage to the mesenteric vessels & intestines, | |
| | (c) blast caused rent in lower right abdomen, intestines protruding from abdominal wound. | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY* OR CONTRIBUTING* CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | Dans Mountain | near Eckhart | Allegany | Md. |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED White at work ☐ | Not while at work ☒ | HOW DID INJURY OCCUR? |
|---|---|---|---|
| Oct.13/51 4.15 P. m. | | | Hunting, sat gun butt down on a rock below him, gun went off |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V.Deming M.D. | H.V. Deming M.D. | Cumberland, Md. | Oct.13-1951 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR ~~CREMATORY~~ | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-16-51 | Bittinger | Bittinger, Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-16-51 | Dan Nancy N. Poe | Joseph R. Dunn, Embalmer | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frostburg (Borden Mines)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg (Borden Mines)
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) HENRY (Middle) ELLSWORTH (Last) WINEBRENNER

4. DATE OF DEATH: (Month) Oct. (Day) 25, (Year) 1951

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: 7-29-1883

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): miner

10b. KIND OF BUSINESS OR INDUSTRY: clay mines

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Winebrenner

14. MOTHER'S MAIDEN NAME: Sarah McKenzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-9866

17. INFORMANT AND ADDRESS: Wm. Winebrenner, Rt. 1, Salisbury, Pa

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Congestive Heart Failure - left side | 2 weeks |
| 442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a | (b) Chronic Hypertensive Cardio-vascular Renal disease | years |
| | (c) Pneumoconiosis - Probably Silicosis | years |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1948, to 25 October 1951, that I last saw the deceased alive on 25 October, 1951, and that death occurred at 7:20 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John B. Davis, M.D. Frostburg Maryland 10/26/51

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 10-27-51

NAME OF CEMETERY OR CREMATORY: Frostburg Mem'l Park

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 10-27-51

REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe

24. FUNERAL DIRECTOR ADDRESS: J. R. Durst, Frostburg, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 26Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Midland
STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print): (First) Aaron (Middle) (Last) Winner

4. DATE OF DEATH: (Month) Oct, (Day) 5 (Year) 1951

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Feb, 16 1916

9. AGE last birthday: 35 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Berkowitz Co. Shirt Factory, Frostburg, Md.

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (State or foreign country): Midland, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Winner

14. MOTHER'S MAIDEN NAME: Emma Heming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 527-10-6763

17. INFORMANT: Mrs. William Winner — Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lung infarct

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) rheumatic heart disease, mitral stenosis

(c)

INTERVAL BETWEEN ONSET AND DEATH: 26 days — over than 20 yr.

410X
9215

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. infectious hepatitis subsided

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☑

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 2, 1951, to October 5, 1951, that I last saw the deceased alive on Oct. 5, 1951, and that death occurred at 8 3 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Elizabeth Krug, M.D. — ADDRESS 55 Greene St. — DATE SIGNED 10/6/51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 8, 1951 — NAME OF CEMETERY OR CREMATORY: St. Anns Cemetery — LOCATION (City, town, or county) (State): Avilton Md.

DATE REC'D BY LOCAL REG.: Oct. 6, 1951 — REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR: M. Eichhorn — ADDRESS: Lonaconing, Md.

VS. A15

OCT
BUREAU V. S.

Within corporate limits Dr. Robinson

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
MARYLAND
LENGTH OF STAY (in this place) 2 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rt #3 Cumberland Rural
STREET ADDRESS (If rural, give location) R.F.D. #3, Bowman's Addition

3. NAME OF DECEASED (Type or Print) (First) harry (Middle) lee (Last) Wise

4. DATE OF DEATH (Month) October (Day) 30 (Year) 1951

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Infant

8. DATE OF BIRTH April 21, 1951

9. AGE last birthday 0 yrs. If under 1 year Months 6 Days | If under 24 hrs. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Raymond Glenn Wise

14. MOTHER'S MAIDEN NAME Margaret Elizabeth Welsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Raymond G. Wise Rt #3 Cumb., Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pneumonia

493X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 109

(b) —

(c) —

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. mental Retardation

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/6, 19 21, to 10/30, 19 51, that I last saw the deceased alive on 10/30, 1951, and that death occurred at 2:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Thomas Robinson M.D. 132 S. Liberty St Cumb. Md 11/1/51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Nov 1, 1951 | NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. Nov. 1, 1951 | REGISTRAR'S SIGNATURE Charles K. Mauk M.D. | 24. FUNERAL DIRECTOR ADDRESS John J. Hafer, Cumberland, Md.

24V405

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

09489

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 16 hrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Cumberland; STREET ADDRESS (If rural, give location): R.F.D.#2 Williams Road

3. NAME OF DECEASED (Type or Print): (First) Irven; (Middle) Glenn; (Last) Wolford

4. DATE OF DEATH: (Month) Oct; (Day) 20; (Year) 1951

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: March 1-1919

9. AGE Last birthday: 32 yrs. If under 1 year: Months; Days; If under 24 hours: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.of Am.

11. BIRTHPLACE (State or foreign country): Slanesville W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Wolford

14. MOTHER'S MAIDEN NAME: Leona Kidwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: 217-10-6767

17. INFORMANT AND ADDRESS: wife) Mary E.Foster Wolford

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

919.8

Immediate cause (a) Shock,also Intrathoracic and intra-abdominal — 17

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

184

(b) hemorrhage,due to 12 guage shotgun wounds — hours

(c) in left side of body & arm.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY* OR CONTRIBUTING* CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: Green Ridge Mt. near (CITY OR TOWN) ~~Cumberland~~ Flintstone, (COUNTY) Allegany (STATE) Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY: Oct.19/51 P. m.

INJURY OCCURRED While at work ☐ Not while at work* ☐

HOW DID INJURY OCCUR? Squirrel hunting, shot accidently by a companion.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland,Md. Oct.20-1951

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 10/22/1951

NAME OF CEMETERY OR CREMATORY: Mt. Union Cemetery

LOCATION (City, town, or county) (State): Slanesville, W.Va

DATE REC'D BY LOCAL REG.: Oct. 22, 1951

REGISTRAR'S SIGNATURE: Walter K. Mantz, M.D.

24. FUNERAL DIRECTOR: Wm. H. Kight

ADDRESS: Cumberland, Md.

NN 466

RECEIVED
OCT 11 1951
BUREAU V. S.

Within corporate limits? DR. ELIASON

09490

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGONY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
MARYLAND
LENGTH OF STAY (In this place): 5 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: PENNSYLVANIA
COUNTY: SOMERSET
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: SALTSBURY
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) RACHEL (Middle) B (Last) YODER

4. DATE OF DEATH: (Month) OCTOBER (Day) 2 (Year) 1951

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: SEPTEMBER 27, 1951

9. AGE last birthday: yrs. | If under 1 year: Months | Days 5 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Salisbury, Penna.

12. CITIZEN OF WHAT COUNTRY: USA.

13. FATHER'S NAME: BENNIE A. YODER

14. MOTHER'S MAIDEN NAME: MIRIAM S. ZOOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, M

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity — Interval between onset and death: 5 days

7764 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
159 (b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9.27.51, 19..., to 10.2.51, 19..., that I last saw the deceased alive on 10-2, 19-51, and that death occurred at 7:15 P m., from the causes and on the date stated above.

SIGNATURE: A M Eliason MD (Degree or title) ADDRESS: 126 Green St Cumberland MD DATE SIGNED: 10-3-51

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 10/4/51 | NAME OF CEMETERY OR CREMATORY: Flag Run Cemetery | LOCATION (City, town, or county) (State): Salisbury, Penn

DATE REC'D BY LOCAL REG.: Oct. 3, 1951 | REGISTRAR'S SIGNATURE: Vinton K. Hartz, M.D. | 24. FUNERAL DIRECTOR: Stanley Thomas, Salisbury, Pa. | ADDRESS

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT [redacted]
BUREAU V. S.